ORB 3.0
User Manual

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Downloading ORB Remote Access

1. Go to **news.ohiohealth.com to download the OhioHealth desktop.**
2. Click on the Green **download** button.
3. Enter the server: **ohconnect.ohiohealth.com**

Logging into the Remote Desktop

1. Click on the **VM Ware** icon on your desktop.
2. Ensure the connection server is ohconnect.ohiohealth.com and select connect

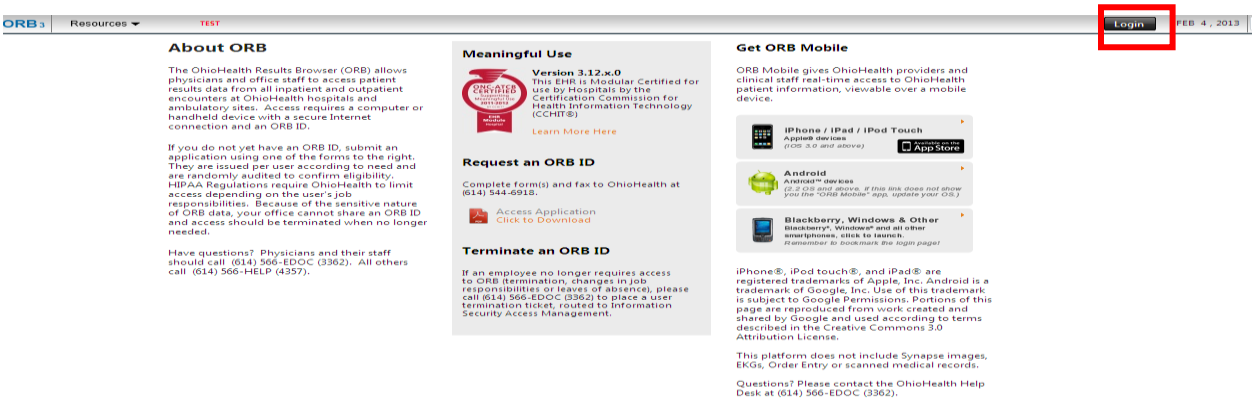
3. Enter your **user name** and **password**.
4. Your phone will ring. Answer and **hit #.** The automated voice will confirm your authentication and you can then end the call.
5. The blue remote desktop screen will start to load.
6. Select **ORB** icon on remote desktop and enter your user name and password if prompted.

7. To log off, select the ***START*** button and choose ***Log Off***. You will be asked to confirm.

Logging Into ORB

1. Select **ORB** icon on the desktop.

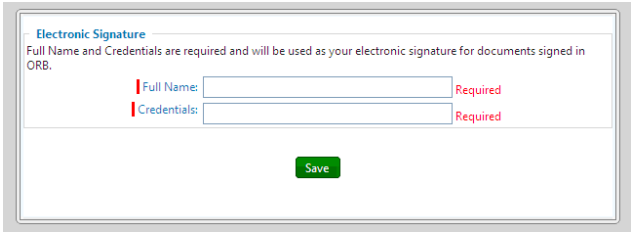
2. Click on the **Login** button in the upper right corner.


ORB 3
Resources
TEST
Login
FEB 4, 2013
About ORB
The OhioHealth Results Browser (ORB) allows physicians and office staff to access patient results data from all inpatient and outpatient encounters at OhioHealth hospitals and ambulatory sites. Access requires a computer or handheld device with a secure Internet connection and an ORB ID.
If you do not yet have an ORB ID, submit an application using one of the forms to the right. They are issued per user according to need and are randomly audited to confirm eligibility. HIPAA Regulations require OhioHealth to limit access depending on the user's job responsibilities. Because of the sensitive nature of ORB data, your office cannot share an ORB ID and access should be terminated when no longer needed.
Have questions? Physicians and their staff should call (614) 566-EDOC (3362). All others call (614) 566-HELP (4357).
Meaningful Use
Version 3.12.x.0
This EHR is Modular Certified for use by Hospitals by the Certification Commission for Health Information Technology (CCHIT®)
Learn More Here
Request an ORB ID
Complete form(s) and fax to OhioHealth at (614) 544-6918.
Access Application
Click to Download
Terminate an ORB ID
If an employee no longer requires access to ORB (termination, changes in job responsibilities or leaves of absence), please call (614) 566-EDOC (3362) to place a user termination ticket, routed to Information Security Access Management.
Get ORB Mobile
ORB Mobile gives OhioHealth providers and clinical staff real-time access to OhioHealth patient information, viewable over a mobile device.
iPhone / iPad / iPod Touch
Apple® devices
(iOS 3.0 and above)
Available on the App Store
Android
Android™ devices
(2.2 OS and above. If this link does not show you the "ORB Mobile" app, update your OS.)
Blackberry, Windows & Other
Blackberry®, Windows® and all other smartphones, click to launch.
Remember to bookmark the login page!
iPhone®, iPod touch®, and iPad® are registered trademarks of Apple, Inc. Android is a trademark of Google, Inc. Use of this trademark is subject to Google Permissions. Portions of this page are reproduced from work created and shared by Google and used according to terms described in the Creative Commons 3.0 Attribution License.
This platform does not include Synapse images, EKGs, Order Entry or scanned medical records.
Questions? Please contact the OhioHealth Help Desk at (614) 566-EDOC (3362).

3. Enter your **username (OPID)** (3 letters, 3 numbers, Example: abc123) and **password**.

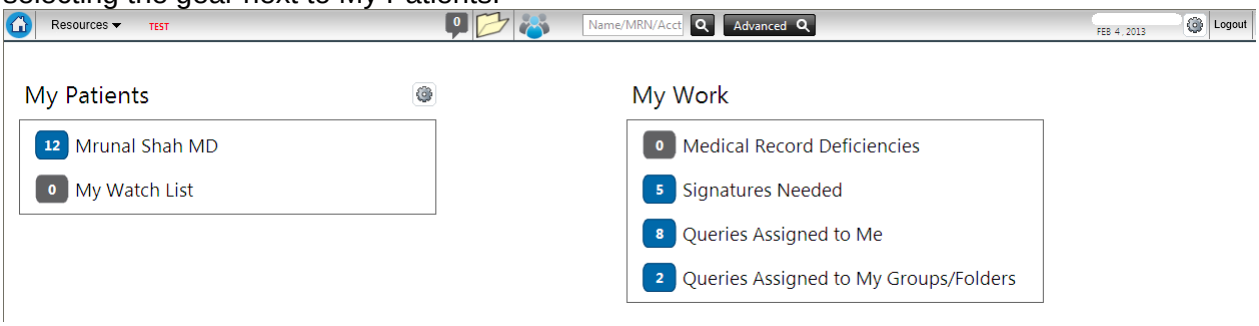
4. Select the **Login** button.

5. The first time you log into ORB, you will need to fill out the Electronic Signature with Credentials. Any changes to your electronic signature can be completed in **User Preferences**.



Home Screen

1. Once you have logged into ORB your home screen will appear. Customize your view by selecting the gear next to My Patients.

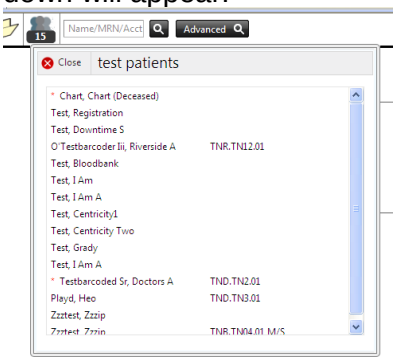


2. The home icon will bring you back to this page.

3. The quote icon will take you to your work and show the number of deficiencies you have.

4. The folder icon will take you to your folders and folder maintenance.

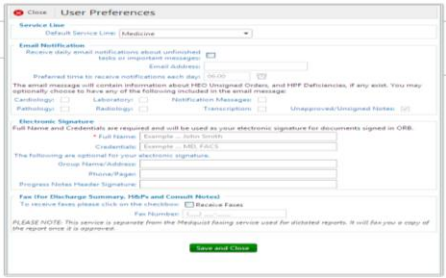
5. The people icon will displays your patients. By hovering on this button a drop down will appear.



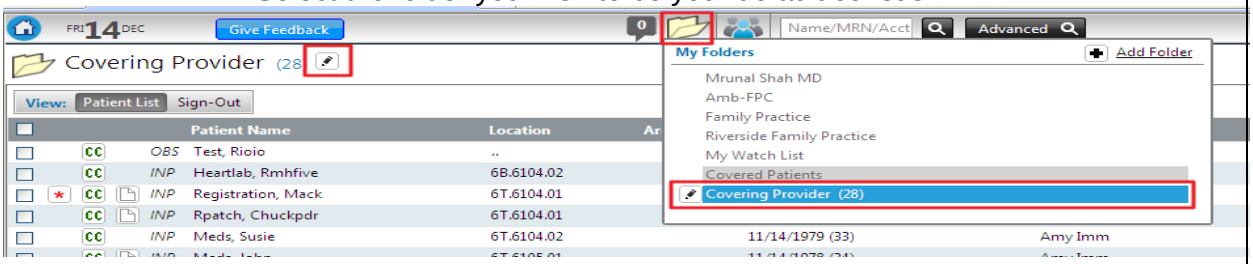
6. Patient search can be done from the header by entering the patients name, medical record number or account number. The advanced search options are still available.

Note: If you search on an older account number and the patient also has a current admission (in a bed or in the ED), you will get a warning that the patient has a current admission and have an option to switch to the current admission.

7. The gear next to your name allows you to adjust your user preferences.
   a. Select your service line
   b. Set up your signature customization
   c. Set up your email notifications
   d. Set up your fax for discharge summaries, H&Ps, and consult notes.

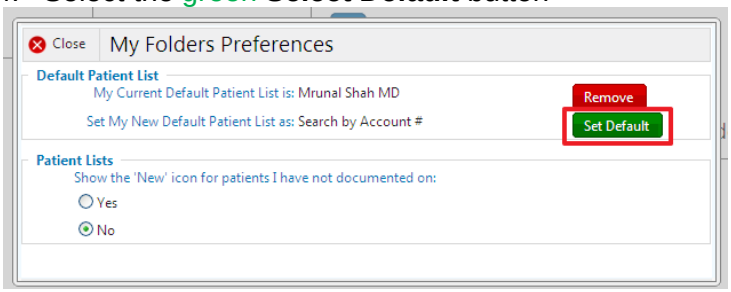


8. My patients
    a. This is your default patient list.
        i. To set up a default patient list:
            1. Select My Folders
            2. Select the folder you wish to be your default census

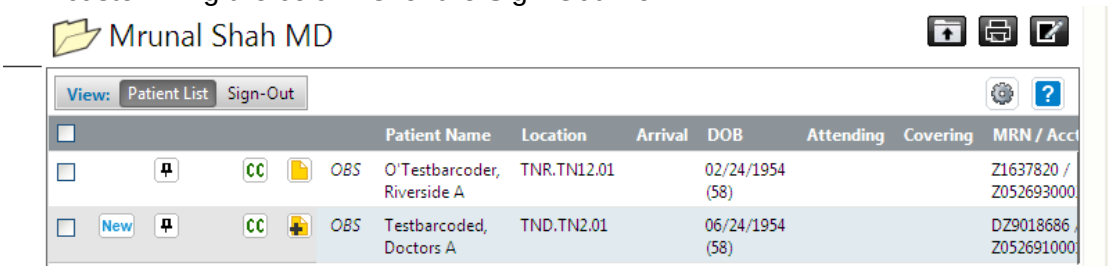


3. Select the marker next to **My Folders**

4. Select the green **Select Default** button


Close
My Folders Preferences
Default Patient List
My Current Default Patient List is: Mrunal Shah MD
Set My New Default Patient List as: Search by Account #
Remove
Set Default
Patient Lists
Show the 'New' icon for patients I have not documented on:
Yes
No

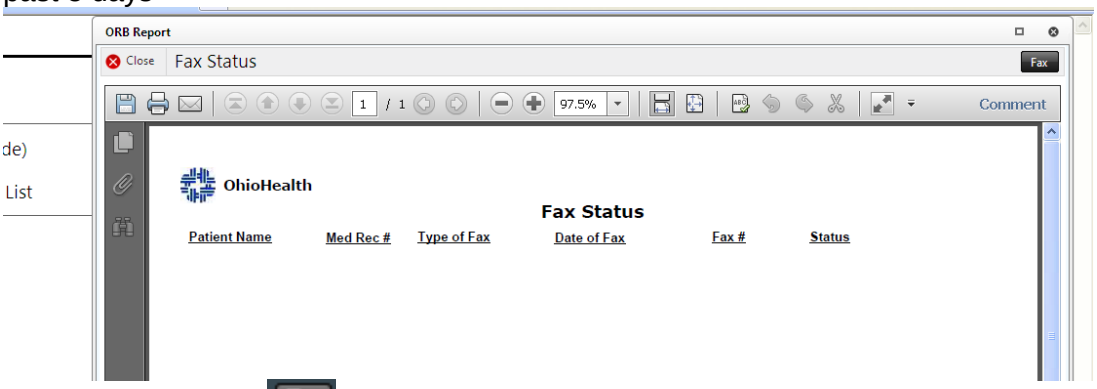
    b. From the patient list the New button represents a new patient that does not have ORB documentation completed by you.
    c. Select the gear to set preferences such as empty beds, Charge Capture icon, surgery times, report preferences (double space, sign out memos, etc.) and customizing the columns for the Sign-Out View



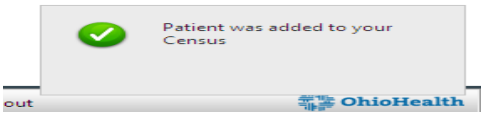
9. My Work
    a. This section contains items that require action such as:
        i. Medical record deficiencies
        ii. Signatures needed on ORB notes and unsigned orders
        iii. CDI queries or review
        iv. Draft notes
        v. Pharmacy queries
    b. Click on the line to process item

10. Fax Status

a. By clicking on fax status, a screen will appear with a list of all faxes sent in the past 5 days



11. Patient Management folder icon will attach the patient to your census, folders, watch list and/or detach the patient. Once a patient is attached or detached, a popup will appear letting you know the patient was either added or detached from your census.



12. Printer icon
    i. View reports sign out memos, patient list, facesheets

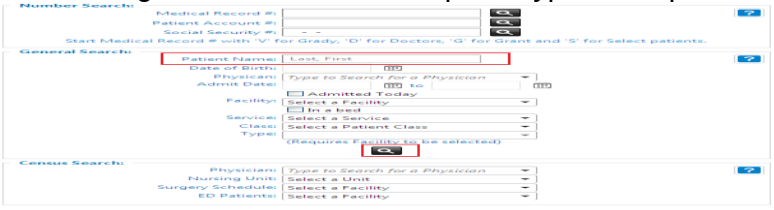
13. Paper/Pencil icon
    i. Batch print/view of the Pre-Anesthesia Evaluation eForm

Note: The Help button is available throughout ORB 3. Click on the Help button to get information about the current section.

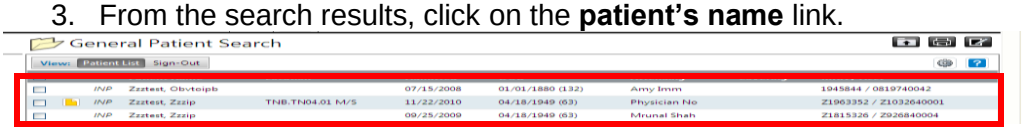
Search Options

1. Click inside the Patient Search box.

2. Using the Advance search option, type in the patient name and click Search

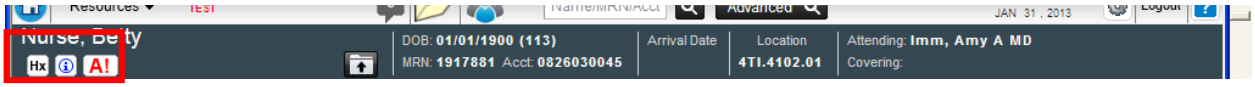


3. From the search results, click on the **patient's name** link.

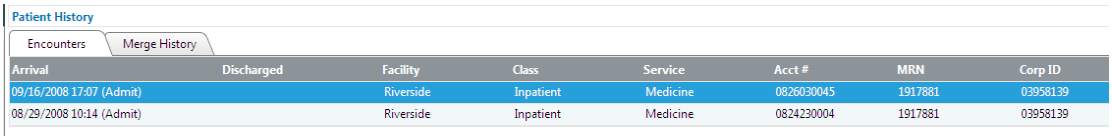


Patient Name Banner

1. The patient name banner has quick reference icons.

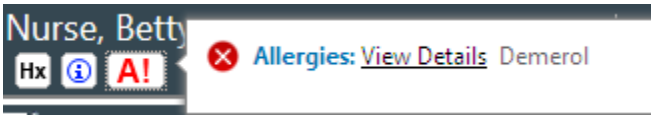


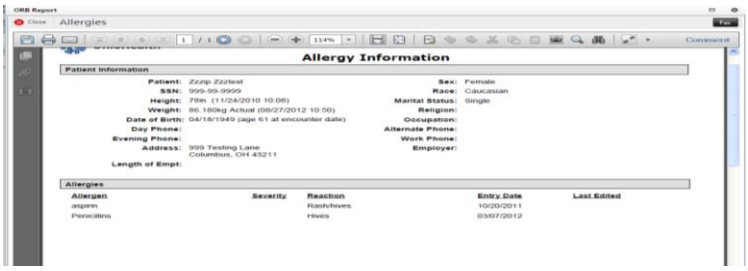
   a. History icon
      i. This will show you a list of encounters



   b. Patient indicator icon
      i. The patient indicator will turn red if the patient has tested positive for C. Diff, CRE, ESBL, MRSA, VRE or if they have been designated a difficult airway patient.

   c. Allergies icon
      i. By clicking on the allergies icon, shows a quick summary of all the allergies with a detail link. Clicking on the details link show the full PDR report.



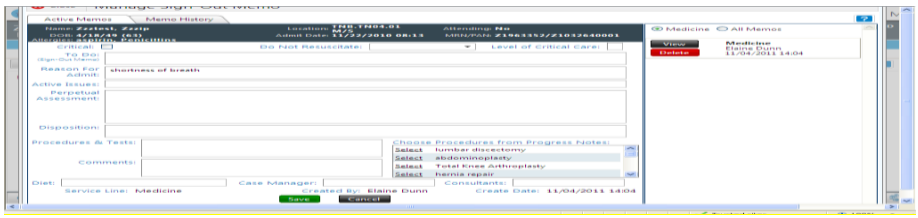


      ii. The Allergy button will appear **A!** if allergies have been documented.
      iii. The allergy button will appear **NKA** if no known allergies have been documented.

iv. The allergy button will appear **A?** if no allergies are documented.

d. Sign-out Memo icon

i. Provides basic patient information and will be visible once a patient is admitted and until 72 hours post-discharge.



ii. Data entered in the same fields as progress notes will automatically appear in the Sign-Out Tools. Data in both places is presented based on patient selected and user's service line. The shared fields include:

To do	This was previously known as the "Sign-out Memo". It is shared with progress notes.
Reason for admission	This data is shared with progress notes.
Perpetual assessment	This data is shared with progress notes.
Disposition	This data is shared with progress notes.

e. Mom Baby icon

i. This allows the toggle between mother and infant

Patient Profile

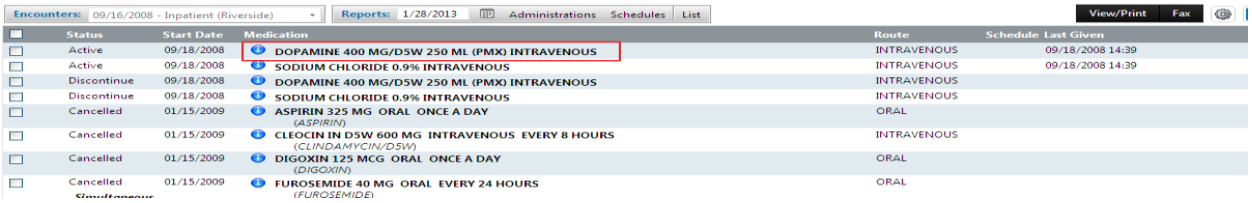
1. Click **Patient Profile** on the toolbar. This link takes you to a list of all OhioHealth encounters.
2. Clicking on an encounter will display the facesheet for the encounter.

Current Orders

1. Click **Orders** on the toolbar. This link takes you to McKesson Physician Portal to view current orders.

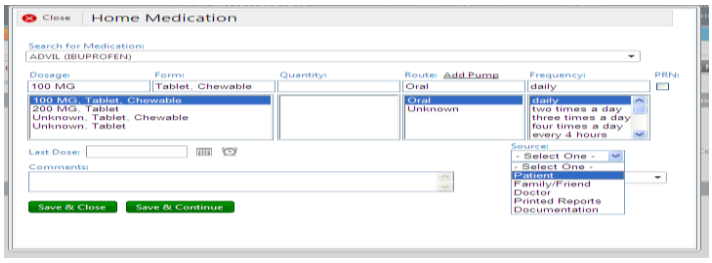
Medications

1. Click Meds on the toolbar. This populates current hospital medication list. The time frame will default to today. You can pull reports based on administration, schedule or the medication list. All home medications are documented here.
2. Hospital Medications
    a. Click on the name of the medication to view medication administration schedule.


Encounters: 09/16/2008 - Inpatient (Riverside)
Reports: 1/28/2013
Administrations
Schedules
List
View/Print
Fax
Status
Start Date
Medication
Route
Schedule
Last Given
Active 09/18/2008 DOPAMINE 400 MG/D5W 250 ML (PMX) INTRAVENOUS INTRAVENOUS 09/18/2008 14:39
Active 09/18/2008 SODIUM CHLORIDE 0.9% INTRAVENOUS INTRAVENOUS 09/18/2008 14:39
Discontinue 09/18/2008 DOPAMINE 400 MG/D5W 250 ML (PMX) INTRAVENOUS INTRAVENOUS
Discontinue 09/18/2008 SODIUM CHLORIDE 0.9% INTRAVENOUS INTRAVENOUS
Cancelled 01/15/2009 ASPIRIN 325 MG ORAL ONCE A DAY (ASPIRIN) ORAL
Cancelled 01/15/2009 CLEOCIN IN D5W 600 MG INTRAVENOUS EVERY 8 HOURS (CLINDAMYCIN/D5W) INTRAVENOUS
Cancelled 01/15/2009 DIGOXIN 125 MCG ORAL ONCE A DAY (DIGOXIN) ORAL
Cancelled 01/15/2009 FUROSEMIDE 40 MG ORAL EVERY 24 HOURS (FUROSEMIDE) ORAL

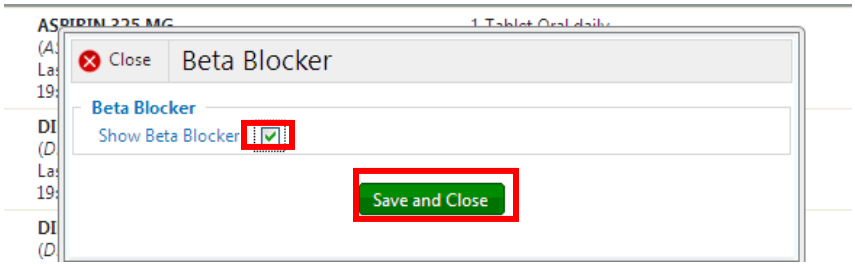
3. Home Medications
    a. To add a home medication select the black plus mark

    b. Type in the name of the medication, dose, form quantity, frequency, last taken, and the source the information came from. Remember to save.



4. To highlight beta blockers on the home medications:
    a. Click on the gear next to **Create Medication Order** button.

    b. Select the **Show Beta Blocker** option.

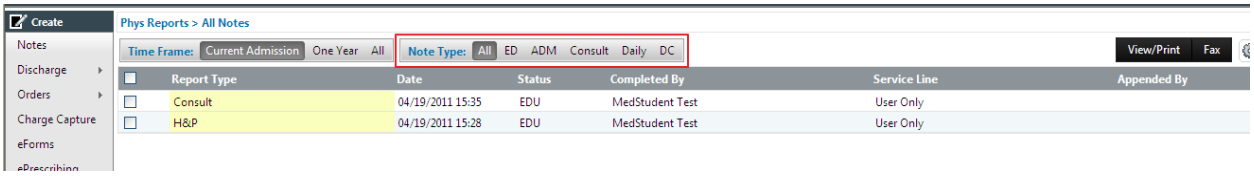


    c. Select the **Save and Close** button.

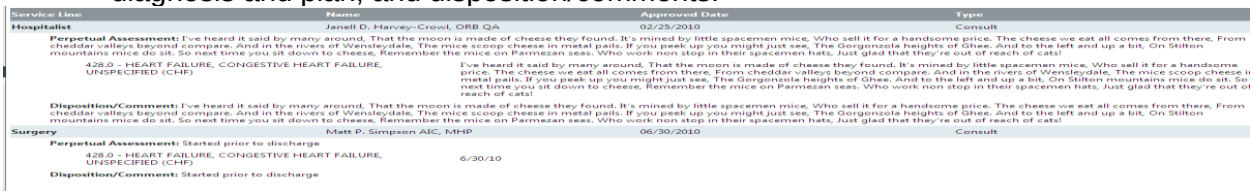
Physician Reports

1. Click **Physician Reports** on the toolbar. This will provide links to physician reports (including history and physicals, consults, operative reports, and emergency room reports), plan view, and rounding report. Click on the **report name** to view the full text. The time frame will default to current admission on reports. Note: if the patient is not currently an inpatient, All Notes will default to ALL.
2. All Notes

All	List of all transcriptions and ORB created documentation.
ED	List of all ED reports from OhioHealth facilities.
Admission	H&P
Consult	Consult notes
Daily	Progress notes Pre-Op and Post-Op notes Procedure notes eForms
Discharge	Discharge Instructions Discharge Summaries


Create
Notes
Discharge
Orders
Charge Capture
eForms
Phys Reports > All Notes
Time Frame: Current Admission One Year All
Note Type: All ED ADM Consult Daily DC
View/Print Fax
Report Type Date Status Completed By Service Line Appended By
Consult 04/19/2011 15:35 EDU MedStudent Test User Only
H&P 04/19/2011 15:28 EDU MedStudent Test User Only

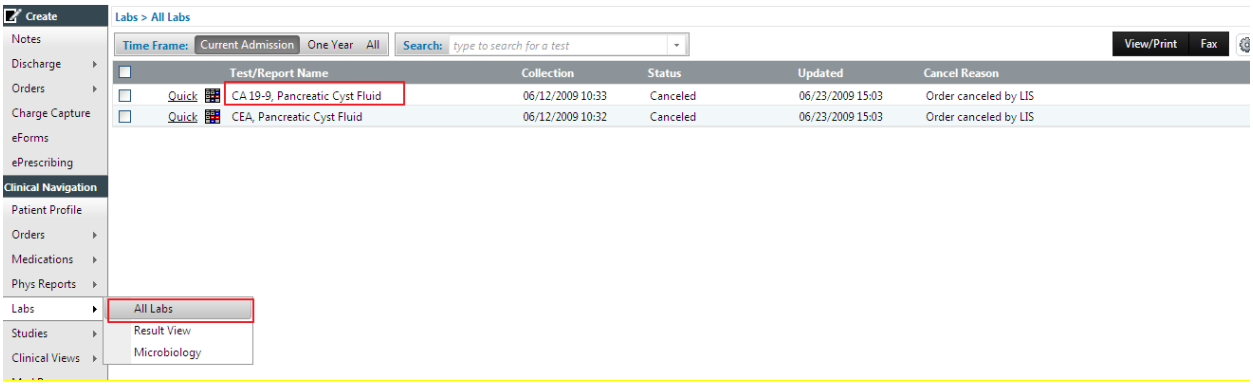
3. Plan View
   a. This view is broken up by service line displaying perpetual assessment, diagnosis and plan, and disposition/comments.



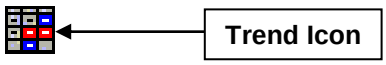
4. Rounding Report
   a. This PDF report pulls documentation for the past 2 days, medications, studies for the past 2 days, and labs for the last 24 hours, and nursing documentation for the past 4 days.

Labs

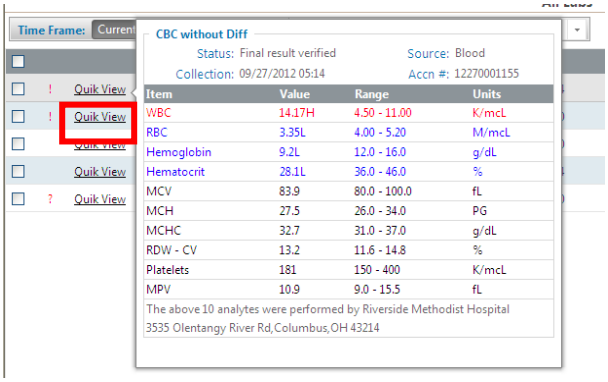
1. Click **Labs** on the toolbar. Use the Search functionality to find a specific test. The time frame will default to current admission on labs. Note: The drop down list has all tests that have been completed on the patient.
2. All Labs
    a. Click on the name of the test to view the reported result.



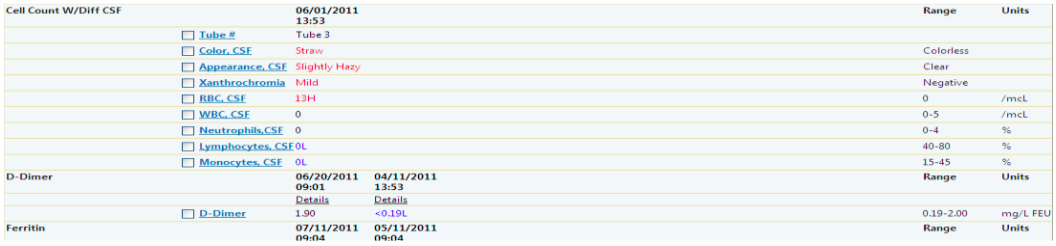
    b. Click on the trend icon to view serial values for the selected lab result.



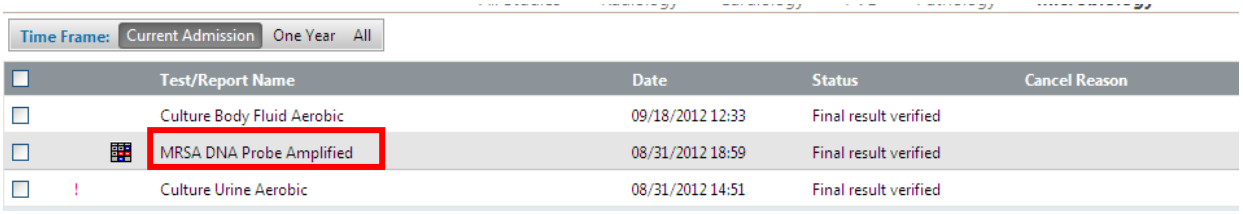
    c. Quick View- Click the quick link to open pop up a window with a hover feature.


Time Frame:
Quik View
Quik View
Quik View
Quik View
CBC without Diff
Status: Final result verified
Source: Blood
Collection: 09/27/2012 05:14
Accn #: 12270001155
Item Value Range Units
WBC 14.17H 4.50 - 11.00 K/mcL
RBC 3.35L 4.00 - 5.20 M/mcL
Hemoglobin 9.2L 12.0 - 16.0 g/dL
Hematocrit 28.1L 36.0 - 46.0 %
MCV 83.9 80.0 - 100.0 fL
MCH 27.5 26.0 - 34.0 PG
MCHC 32.7 31.0 - 37.0 g/dL
RDW - CV 13.2 11.6 - 14.8 %
Platelets 181 150 - 400 K/mcL
MPV 10.9 9.0 - 15.5 fL
The above 10 analytes were performed by Riverside Methodist Hospital
3535 Olentangy River Rd,Columbus,OH 43214

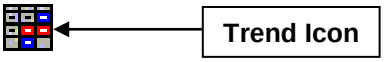
3. Results View
    a. This filtered view gives the ability to view and trend analytes.



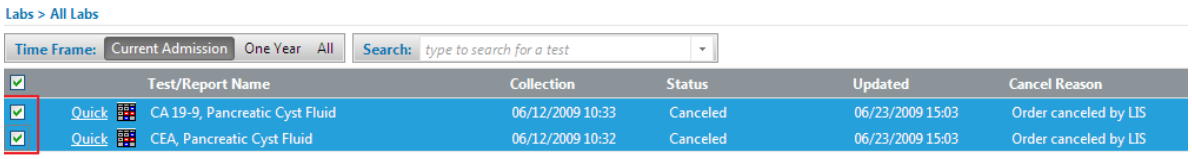
4. Microbiology
    a. Click the name of the exam to view the interpretation



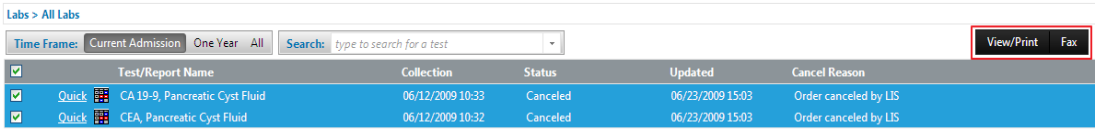
    b. **Click on the trend icon to view serial** values for the selected lab result.



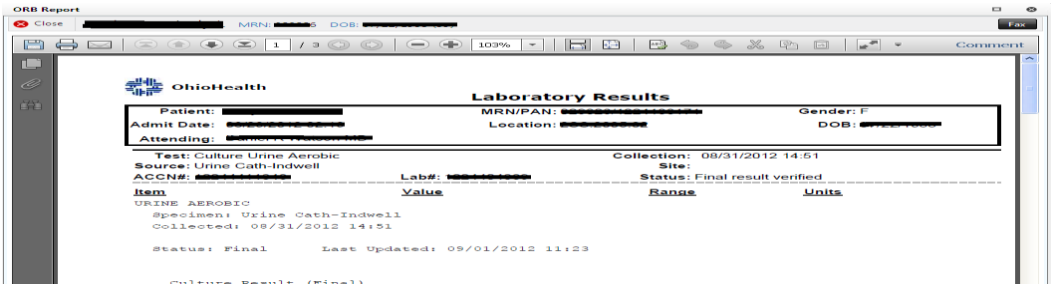
5. To Print or Fax a study.
    a. Select the studies you wish to be printed or faxed by placing a checkmark in the box next to the study's name.


Labs > All Labs
Time Frame: Current Admission One Year All
Search: type to search for a test
Test/Report Name
Collection
Status
Updated
Cancel Reason
Quick CA 19-9, Pancreatic Cyst Fluid 06/12/2009 10:33 Canceled 06/23/2009 15:03 Order canceled by LIS
Quick CEA, Pancreatic Cyst Fluid 06/12/2009 10:32 Canceled 06/23/2009 15:03 Order canceled by LIS

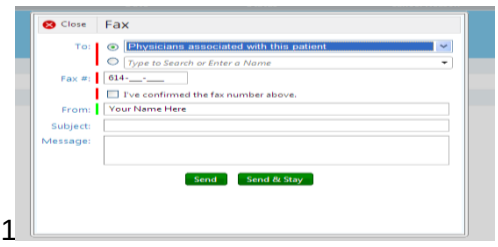
    b. Select the Print or Fax button


Labs > All Labs
Time Frame: Current Admission One Year All
Search: type to search for a test
View/Print
Fax
Test/Report Name
Collection
Status
Updated
Cancel Reason
Quick CA 19-9, Pancreatic Cyst Fluid 06/12/2009 10:33 Canceled 06/23/2009 15:03 Order canceled by LIS
Quick CEA, Pancreatic Cyst Fluid 06/12/2009 10:32 Canceled 06/23/2009 15:03 Order canceled by LIS

    c. When you select the Print button. A PDF of all the selected studies will populate. There is also an option to fax from this view.

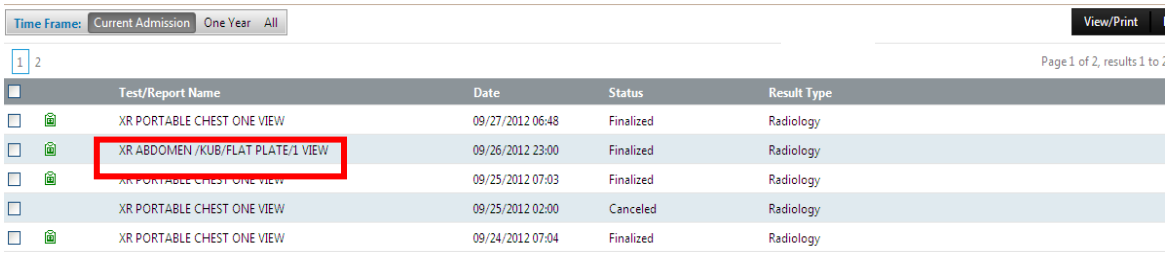


    d. Select the fax button to fax the report(s) to a physician. Send and stay will allow you to enter additional providers without reopening the fax window.

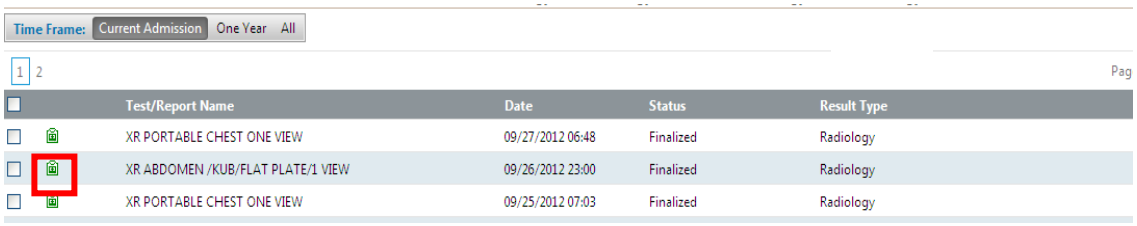


Studies

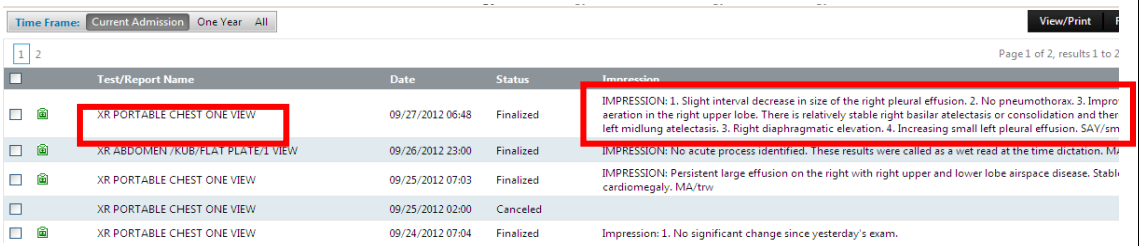
1. Click **Studies** on the toolbar. Click the name of the exam to view the interpretation. Click on the image icon to view the actual exam image. The time frame will default to current admission on reports.
2. All Studies
    a. This view will list all radiology, cardiology, PVL, and pathology.
    b. Click on the name of the exam to view the interpretation.


Time Frame: Current Admission One Year All
View/Print
Page 1 of 2, results 1 to
Test/Report Name
Date
Status
Result Type
XR PORTABLE CHEST ONE VIEW 09/27/2012 06:48 Finalized Radiology
XR ABDOMEN /KUB/FLAT PLATE/1 VIEW 09/26/2012 23:00 Finalized Radiology
09/25/2012 07:03 Finalized Radiology
XR PORTABLE CHEST ONE VIEW 09/25/2012 02:00 Canceled Radiology
XR PORTABLE CHEST ONE VIEW 09/24/2012 07:04 Finalized Radiology

    c. Click on the image icon (if listed) to view the exam image.


Time Frame: Current Admission One Year All
Test/Report Name
Date
Status
Result Type
XR PORTABLE CHEST ONE VIEW 09/27/2012 06:48 Finalized Radiology
XR ABDOMEN /KUB/FLAT PLATE/1 VIEW 09/26/2012 23:00 Finalized Radiology
XR PORTABLE CHEST ONE VIEW 09/25/2012 07:03 Finalized Radiology

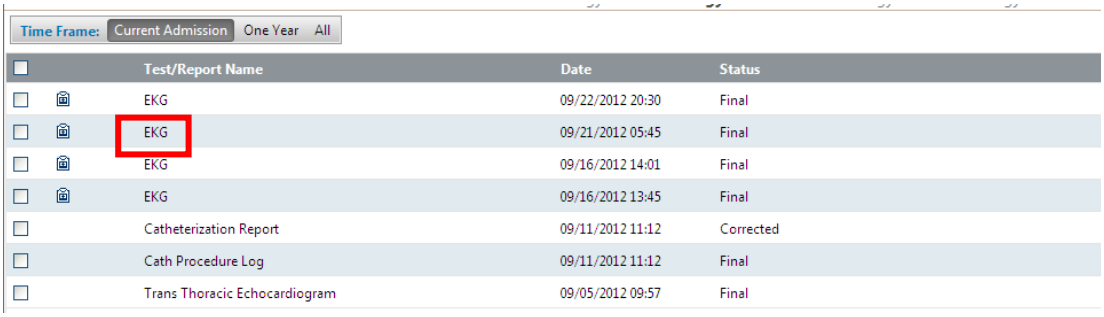
3. Radiology
    a. Click the name of the exam to view the interpretation. Click on the image icon to view the actual exam image. The impression for that study will appear next to the status column. Note: if you do not see an impression, verify the status of the study.


Time Frame: Current Admission One Year All
View/Print
Page 1 of 2, results 1 to 2
Test/Report Name
Date
Status
Impression
XR PORTABLE CHEST ONE VIEW 09/27/2012 06:48 Finalized IMPRESSION: 1. Slight interval decrease in size of the right pleural effusion. 2. No pneumothorax. 3. Impro aeration in the right upper lobe. There is relatively stable right basilar atelectasis or consolidation and ther left midlung atelectasis. 3. Right diaphragmatic elevation. 4. Increasing small left pleural effusion. SAV/sm
XR ABDOMEN /KUB/FLAT PLATE/1 VIEW 09/26/2012 23:00 Finalized IMPRESSION: No acute process identified. These results were called as a wet read at the time dictation. M
XR PORTABLE CHEST ONE VIEW 09/25/2012 07:03 Finalized IMPRESSION: Persistent large effusion on the right with right upper and lower lobe airspace disease. Stabl cardiomegaly. MA/trw
XR PORTABLE CHEST ONE VIEW 09/25/2012 02:00 Canceled
XR PORTABLE CHEST ONE VIEW 09/24/2012 07:04 Finalized Impression: 1. No significant change since yesterday's exam.

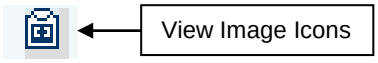
=verified and dictated
= preliminary

View Image Icons

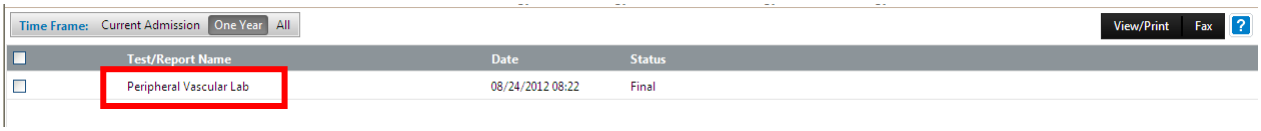
4. Cardiology
    a. Click the name of the exam to view the interpretation.


Time Frame: Current Admission One Year All
Test/Report Name
Date
Status
EKG 09/22/2012 20:30 Final
EKG 09/21/2012 05:45 Final
EKG 09/16/2012 14:01 Final
EKG 09/16/2012 13:45 Final
Catheterization Report 09/11/2012 11:12 Corrected
Cath Procedure Log 09/11/2012 11:12 Final
Trans Thoracic Echocardiogram 09/05/2012 09:57 Final

    b. Click on the image icon to view the actual exam image.



5. PVL (Peripheral Vascular Lab)
    a. Click the name of the exam to view the interpretation.

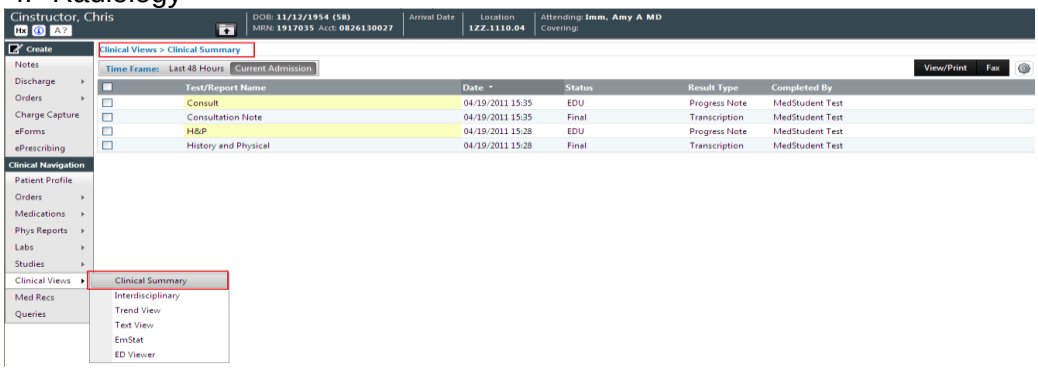


6. Pathology
    a. Click the name of the exam to view the interpretation.

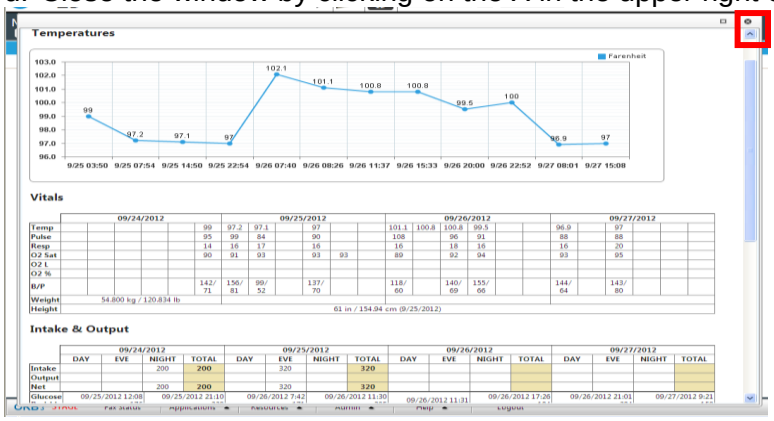
Clinical Views

3. Click **Clinical Views** on toolbar. This will provide links to Clinical Summary, Interdisciplinary, Trend View, Text View, EmSTAT, and ED Viewer. Click on the **report name** to view the full text. The time frame will default to last 48 hours on reports.

4. Clinical Summary
   a. Defaults to the last 48 hours
   b. Clinical Summary Contains: All ORB created notes
   c. Transcriptions
   d. Labs
   e. Cardiology
   f. Radiology



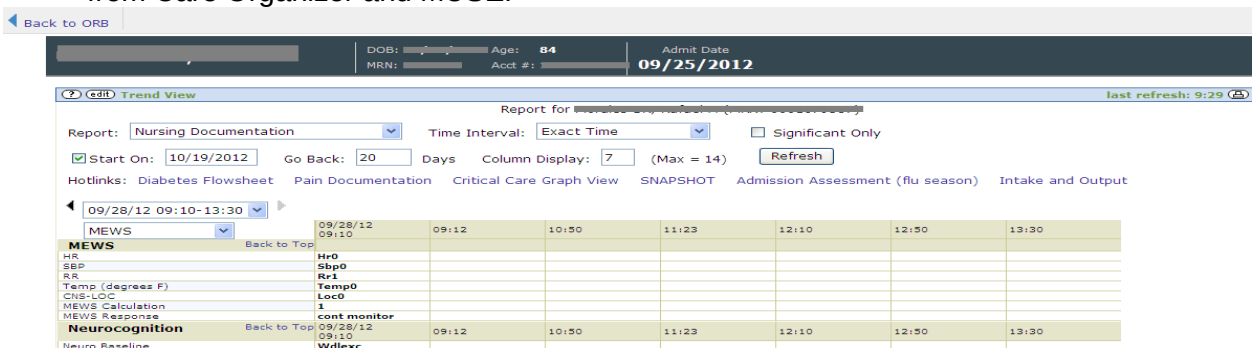
5. Interdisciplinary
   a. Select Interdisciplinary
   b. Popup window with graphic view of vital signs and input/output.
   c. Below the nursing documentation, clinical nutrition, occupational, speech & physical therapy, social work, wound, Hospice documentation can be found.
   d. Close the window by clicking on the X in the upper right corner.



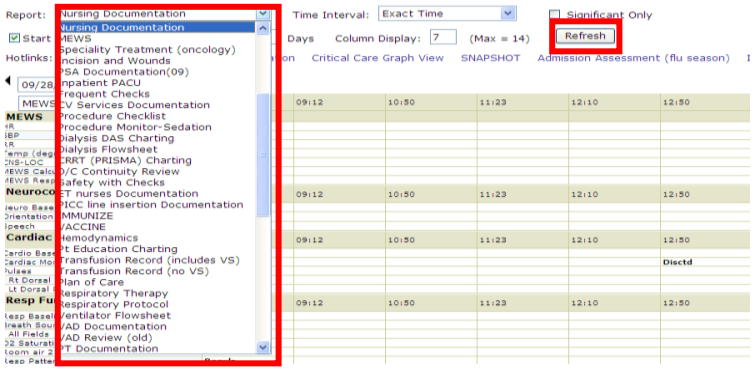
6. Chemotherapy
   a. This provides a consolidated view for when and what facility a patient received treatment.

7. Trend View

a. This link takes you to McKesson Physician Portal to view clinical documentation from Care Organizer and MUSE.

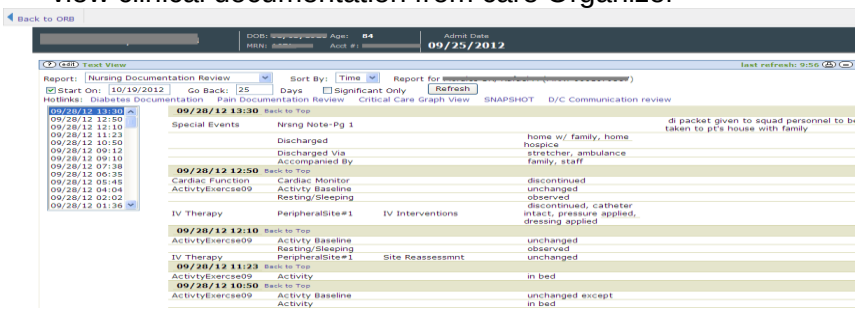


b. Select the **documentation** type from the drop down and select **refresh.**

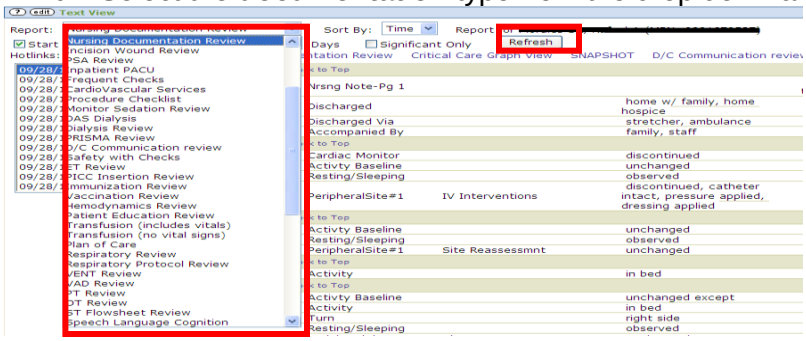


8. Text View

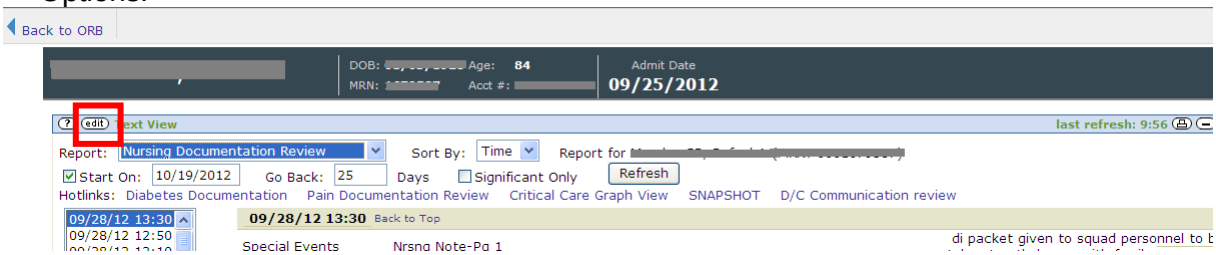
a. By clicking on Trend View this link takes you to McKesson Physician Portal to view clinical documentation from care Organizer



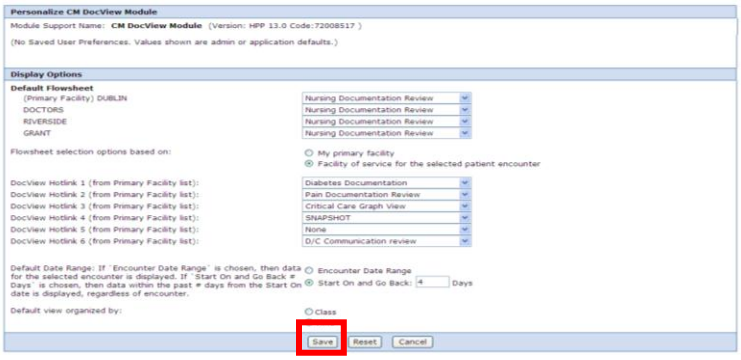
b. Select the **documentation** type from the drop down and select **refresh**.



c. Select the **Edit** button to modify the default flow sheet at all campuses under Display Options.



d. Once updated click **Save** at the bottom of the page. The newly selected default flow sheets will be displayed for subsequent logins.



9. EmSTAT
   a. EmSTAT is a link into the emergency room documentation system from Westerville, Riverside and Grant.
   b. If you need access please call 614-566-HELP (4357)

10. ED Viewer
   a. Provides a link to Horizon Emergency Care documentation from Dublin and Doctors Hospital.

Medical Records

1. Click **Medical Record** on the toolbar. This link takes you to McKesson Medical Records Portal to view the entire patient's current and past legal medical record. Select the back to ORB link to return to ORB.
2. Once selected, from the left side of the screen, you can select to view a patient's medical record grouped by either encounter or document type.

3. To bookmark a document:
    a. Click on the document in the document tree to be bookmarked.
    b. Click the '*Bookmark*' button on the toolbar.
4. To print click on the '*Print*' button on the tool bar.

5. To personalize how you view groups of documents
    a. Select *File* then *Preferences.*
    b. Select *Personal Record View.*
    c. Select the documents you want in your personal record view then click *Add*.
    d. To include all of the accessible documents, click on *Add All*.

6. To Change your PIN
    a. Select the *edit* button located in the top left corner of the application screen. *Note: For first time use only, OLD PASSWORD is the last four digits of your SSN.*

7. To Complete Deficiencies
    a. Select *Deficiency Type* in the top left corner.
    b. Select Group worklist or Individual worklist to see those encounters that you need to dictate. You will need to dictate this report using the normal process via MedQuist.
    c. Click on the check box(es) to select the deficiency.
    d. Select *Process* to view and complete a single deficiency or, click on *Process All* to view and complete all of your Signature deficiencies.
    e. The PIN Required window will open. You will only need to enter your PIN once per chart completion session.

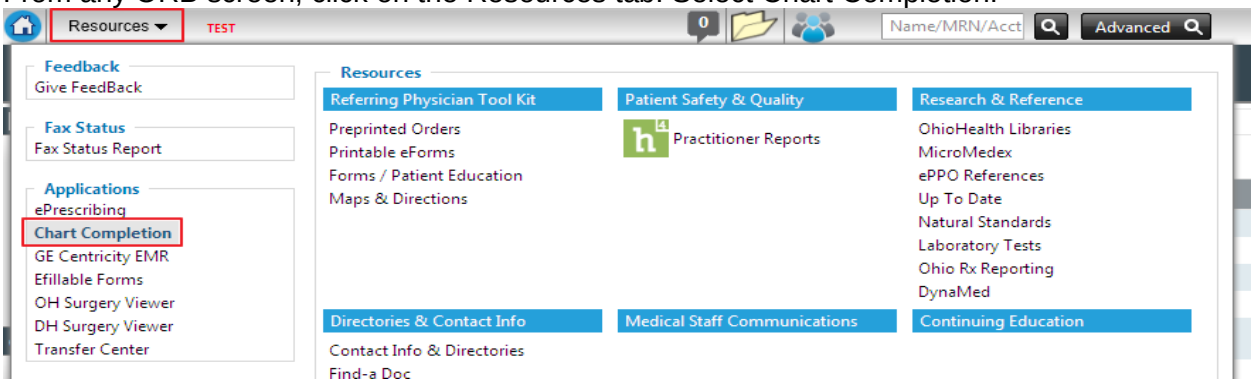
8. To add or edit text
    a. Click in the document where you want to start typing. Be sure to edit *BEFORE* you sign the deficiency.
    b. Click the *Sign Button* to complete the deficiency.

9. Missing Text
    a. Enter the missing text in the yellow text box.
    b. Maximum of 240 characters.
    c. Your initials, date and time are added to the bottom of the page.
    d. Once all text is entered in each box, click the C*omplete* button to complete the Missing Text deficiency.

10. To Decline Deficiency
    a. Click the check box next to the document you wish to decline.

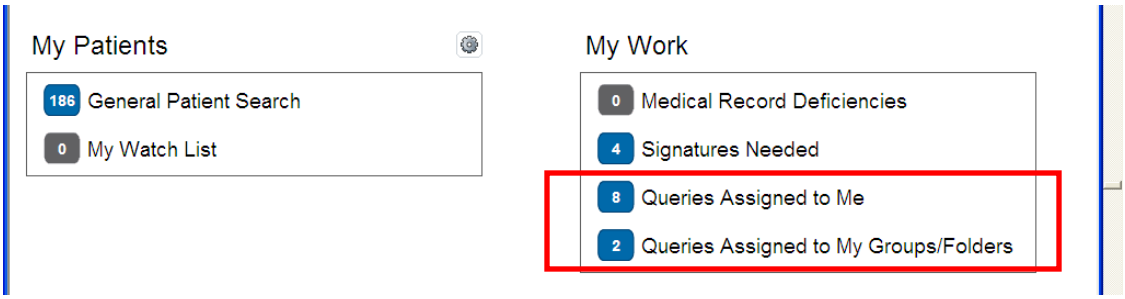
b. Then click the *Decline* button.
c. Select a standard reason from the drop down menu, or enter your own reason with a maximum of 225 characters.
d. Click *OK* to save your deficiency decline and reason.

11. From any ORB screen, click on the Resources tab. Select Chart Completion.

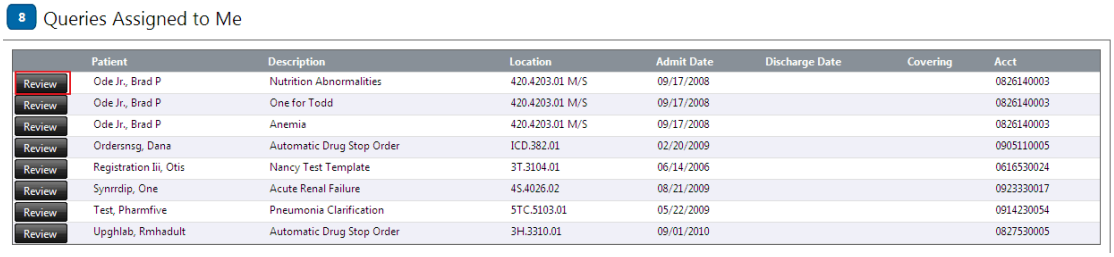


Queries

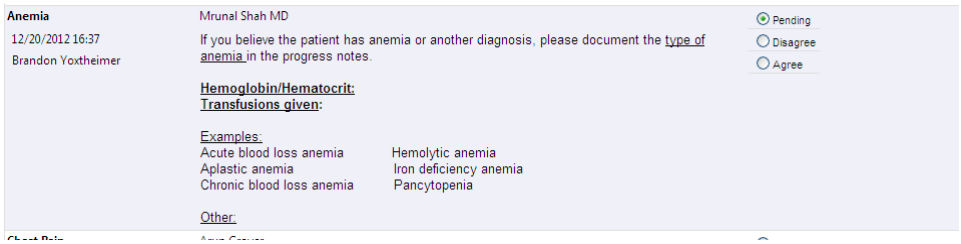
1. On the ORB 3 home page, the CDI and Pharmacy queries assigned to either you or your groups/folders will appear under My Work. Click one of the links to view the queries.
    a. Queries Assigned to Me are queries assigned specifically to you.
    b. Queries Assigned to My Group/Folders are queries assigned to one of your physician groups OR is associated with a patient in one of your folders. You can edit your shared folders through this icon on the ORB home page.



2. Select the Review button next to the query you want to review. **For the queries in the My Group/Folders category, only respond to the ones associated with your patients.**

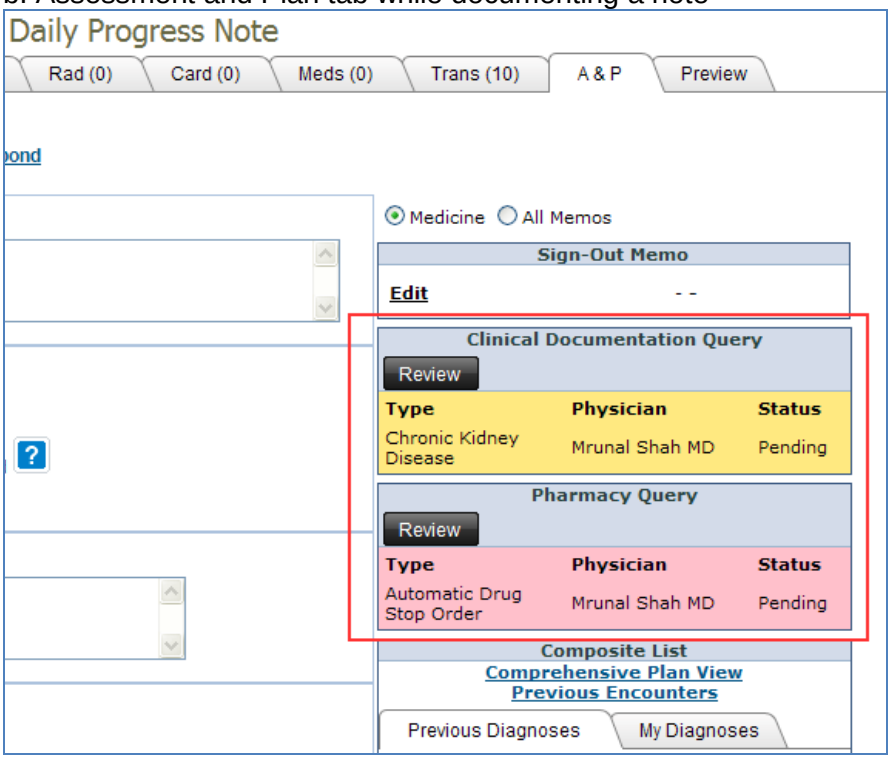

8 Queries Assigned to Me
Patient
Description
Location
Admit Date
Discharge Date
Covering
Acct
Review Ode Jr., Brad P Nutrition Abnormalities 420.4203.01 M/S 09/17/2008 0826140003
Review Ode Jr., Brad P One for Todd 420.4203.01 M/S 09/17/2008 0826140003
Review Ode Jr., Brad P Anemia 420.4203.01 M/S 09/17/2008 0826140003
Review Ordersnsg, Dana Automatic Drug Stop Order ICD.382.01 02/20/2009 0905110005
Review Registration Iii, Otis Nancy Test Template 3T.3104.01 06/14/2006 0616530024
Review Synrrdip, One Acute Renal Failure 4S.4026.02 08/21/2009 0923330017
Review Test, Pharmfive Pneumonia Clarification 5TC.5103.01 05/22/2009 0914230054
Review Upghlab, Rmhadult Automatic Drug Stop Order 3H.3310.01 09/01/2010 0827530005

3. The query review window will open.
    a. Review the query and choose either Agree or Disagree.
    b. Be sure to update your response documentation **in the progress note** regardless of agreement. Do not select agree/disagree on a patient if you are not providing care for this patient.

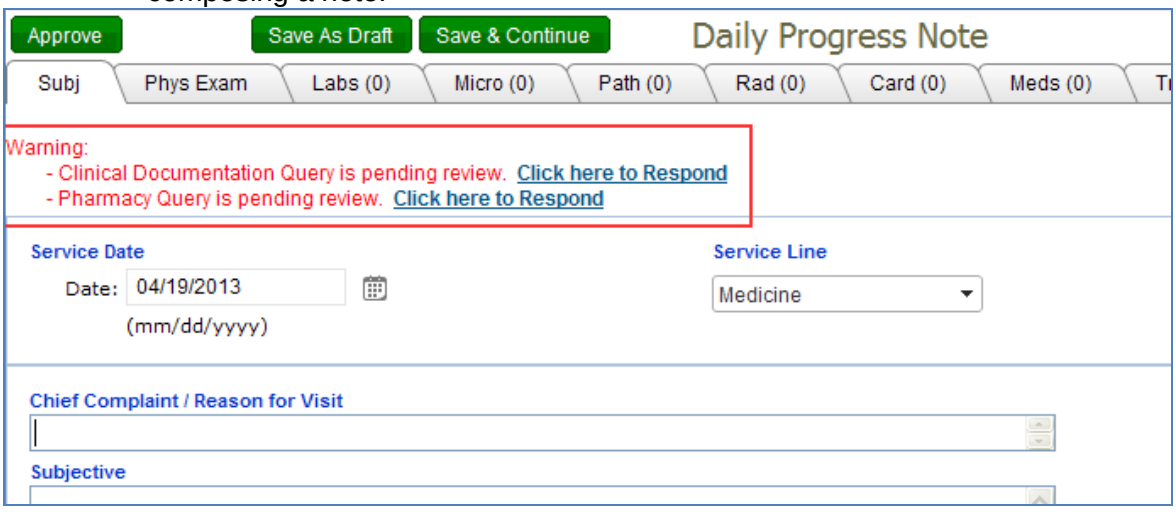


4. Queries can also be responded to from the following locations in ORB:
    a. Clinical Navigation → Queries tab

b. Assessment and Plan tab while documenting a note

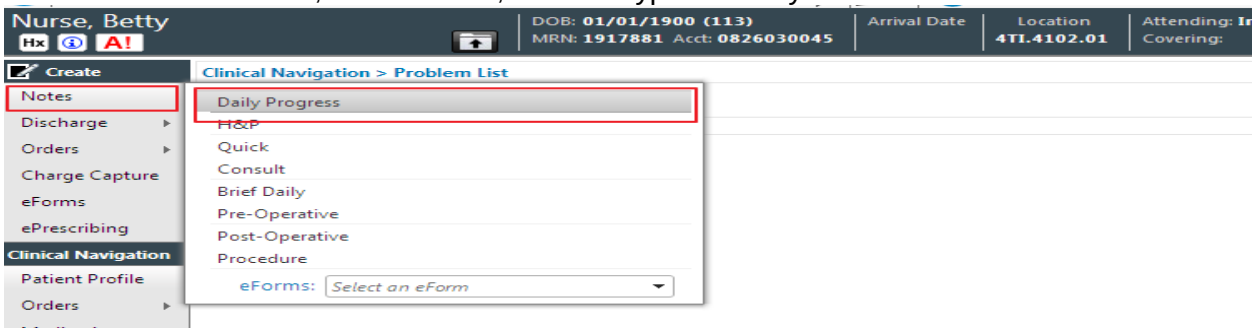


c. If there is a query on the patient, a message will also appear on each tab when composing a note.

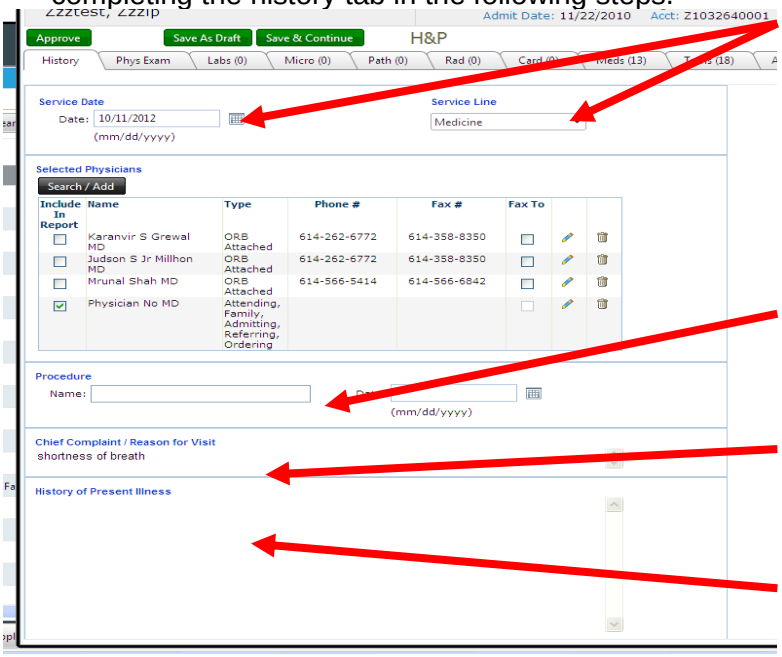


Completing Notes in ORB

1. Under the **Create** menu, select **Notes**, then the type of note you wish to create.



2. The first tab in the **Progress Note** or **Consul**t will be the ***History Tab.*** We will walk through completing the history tab in the following steps.

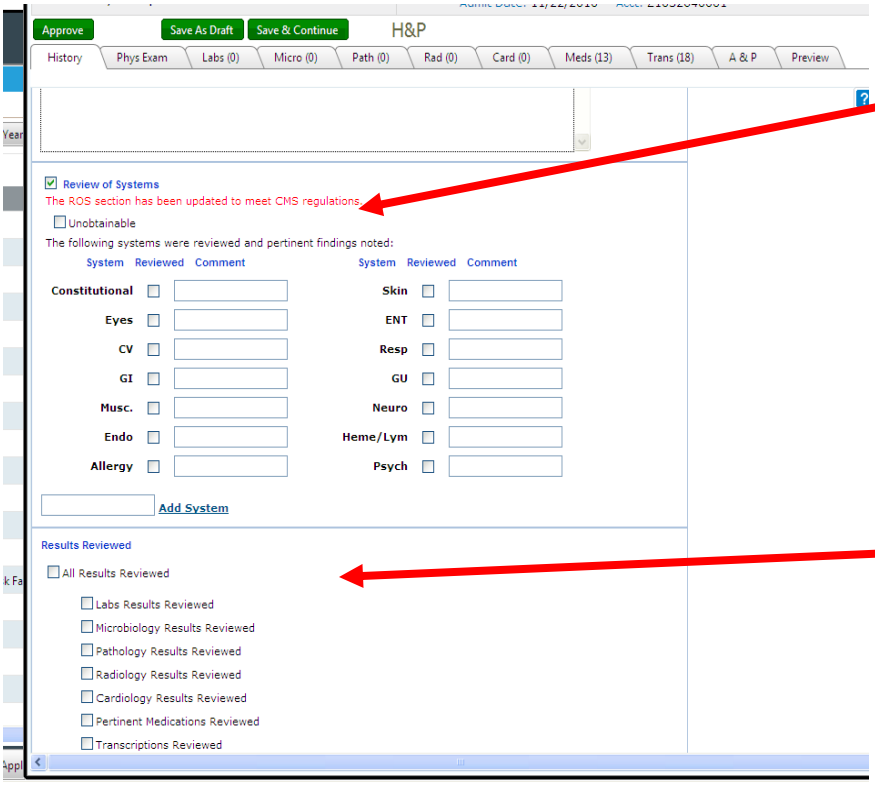


Select the Date and Service Line (this can be set as a default in User Preferences)

Enter the Procedure if indicated.

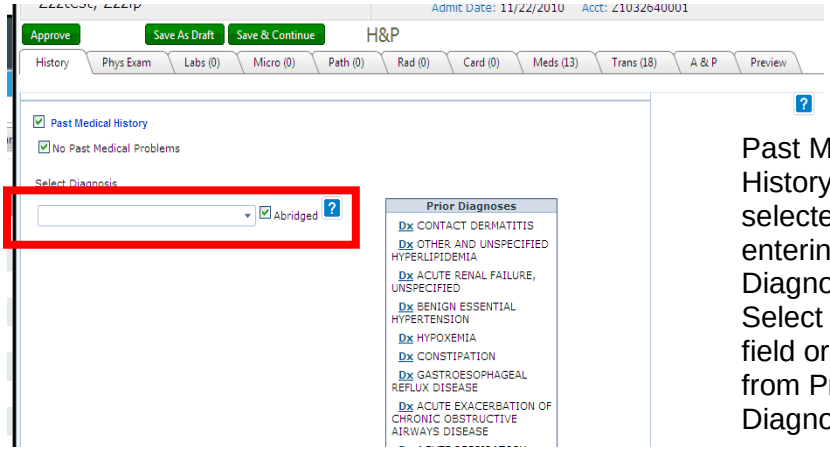
Enter the Chief Complaint / Reason for Visit

The History of Present Illness can be entered via the free text box.

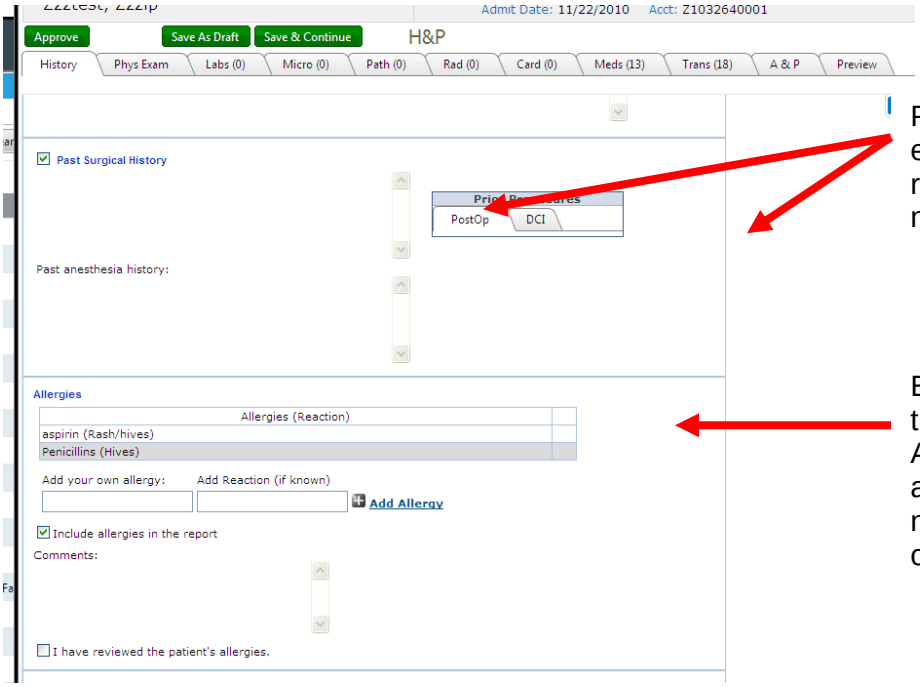


Check the applicable systems reviewed. Comments can be entered for each system.

Check the applicable **Results Reviewed**. This can be completed on individual tabs as well.

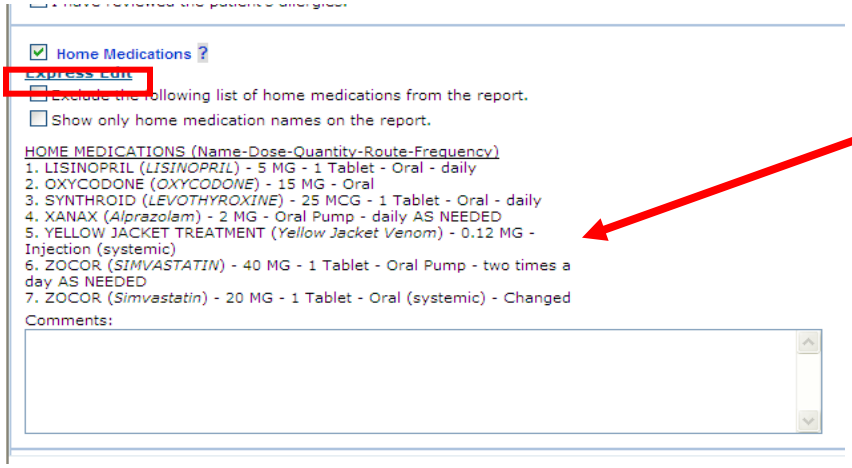


Past Medical History can be selected by entering a Diagnosis into the Select Diagnosis field or selecting from Prior Diagnoses.

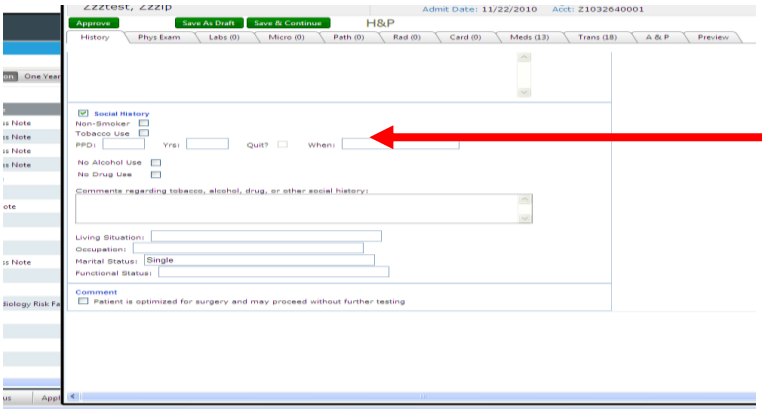


Past Surgical History can be entered via the text boxes. A reference for prior procedure notes will be shown if available.

Enter patient allergies by typing in the **Allergies** selection field. Allergies selections will populate as you type. If your selection is not available, you can add your own allergy to the patient list.

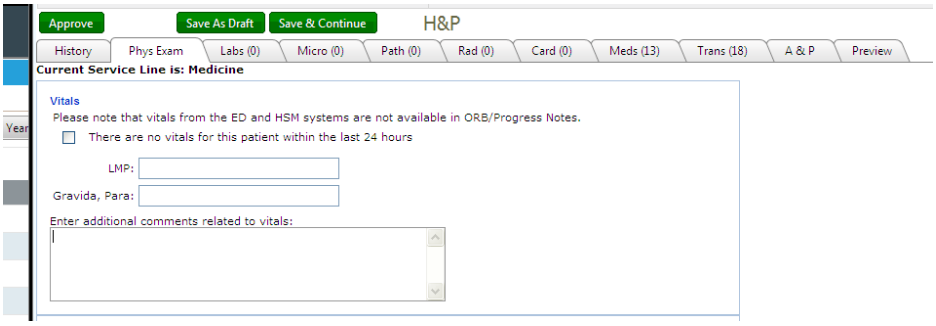

Home Medications
Express Edit
Show only home medication names on the report.
HOME MEDICATIONS (Name-Dose-Quantity-Route-Frequency)
1. LISINOPRIL (LISINOPRIL) - 5 MG - 1 Tablet - Oral - daily
2. OXYCODONE (OXYCODONE) - 15 MG - Oral
3. SYNTHROID (LEVOTHYROXINE) - 25 MCG - 1 Tablet - Oral - daily
4. XANAX (Alprazolam) - 2 MG - Oral Pump - daily AS NEEDED
5. YELLOW JACKET TREATMENT (Yellow Jacket Venom) - 0.12 MG - Injection (systemic)
6. ZOCOR (SIMVASTATIN) - 40 MG - 1 Tablet - Oral Pump - two times a day AS NEEDED
7. ZOCOR (Simvastatin) - 20 MG - 1 Tablet - Oral (systemic) - Changed
Comments:

The patient's **Home Medications** will be listed for your review. You can also select **Express Edit** to add or edit home medications.



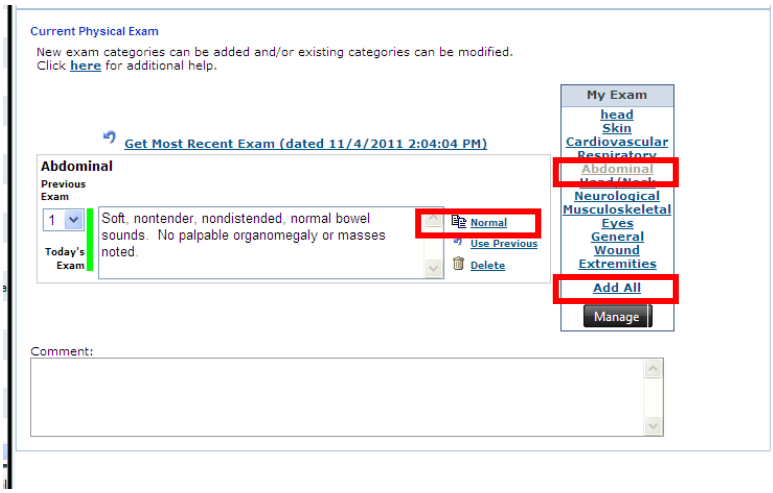
The Social History is completed by selecting the patient's tobacco and alcohol use, living situation, occupation, marital status, and functional status. Additional comments can be entered via the Comments text box.

3. The next tab will be the ***Physical Exam Tab***. From this tab you can review patient vitals, I/O's, and the Graphic Record. You can also enter free text comments relating to the vital signs.

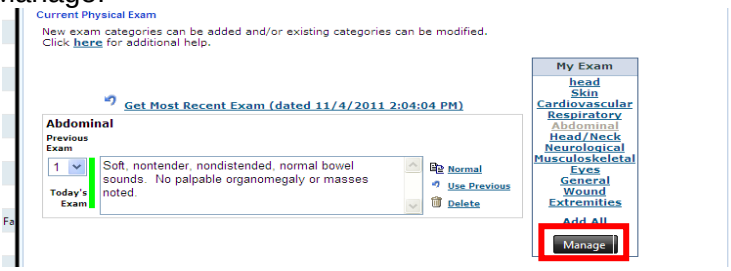


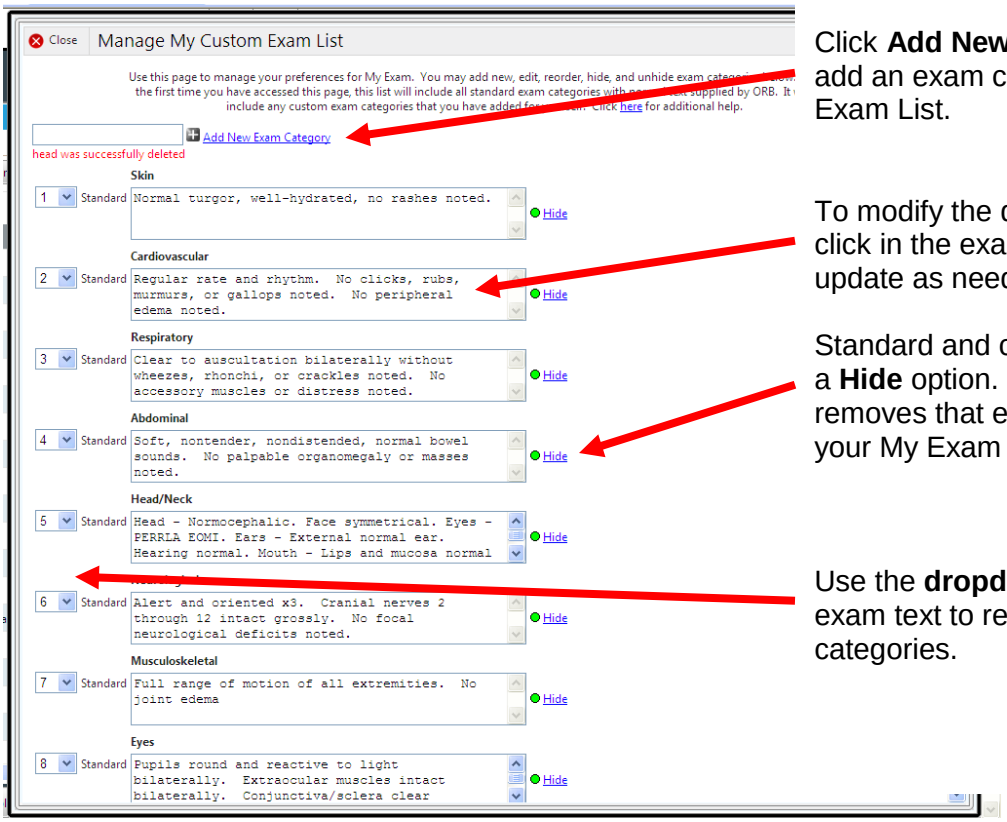
b. Physical Exam components can be added to the note using the ***My Exam List***.

i. To start an exam, make a selection from My Exam on the right side of the page.
ii. Click on the name of a specific physical exam category to add it to the note. The exam will be added with the default normal text.
iii. Exam text can be edited by clicking in the text box and entering desired text.
iv. To add all listed exam categories, select Add All on the My Exam List.



c. The My Exam List can be customized to meet your preferences by clicking Manage.




Close
Manage My Custom Exam List
Use this page to manage your preferences for My Exam. You may add new, edit, reorder, hide, and unhide exam categories. The first time you have accessed this page, this list will include all standard exam categories with default text supplied by ORB. It will include any custom exam categories that you have added for My Exam. Click here for additional help.
Add New Exam Category
head was successfully deleted
Skin
1 Standard
Normal turgor, well-hydrated, no rashes noted.
Hide
Cardiovascular
2 Standard
Regular rate and rhythm. No clicks, rubs, murmurs, or gallops noted. No peripheral edema noted.
Hide
Respiratory
3 Standard
Clear to auscultation bilaterally without wheezes, rhonchi, or crackles noted. No accessory muscles or distress noted.
Hide
Abdominal
4 Standard
Soft, nontender, nondistended, normal bowel sounds. No palpable organomegaly or masses noted.
Hide
Head/Neck
5 Standard
Head - Normocephalic. Face symmetrical. Eyes - PERRLA EOMI. Ears - External normal ear. Hearing normal. Mouth - Lips and mucosa normal
Hide
6 Standard
Alert and oriented x3. Cranial nerves 2 through 12 intact grossly. No focal neurological deficits noted.
Hide
Musculoskeletal
7 Standard
Full range of motion of all extremities. No joint edema
Hide
Eyes
8 Standard
Pupils round and reactive to light bilaterally. Extraocular muscles intact bilaterally. Conjunctiva/sclera clear
Hide

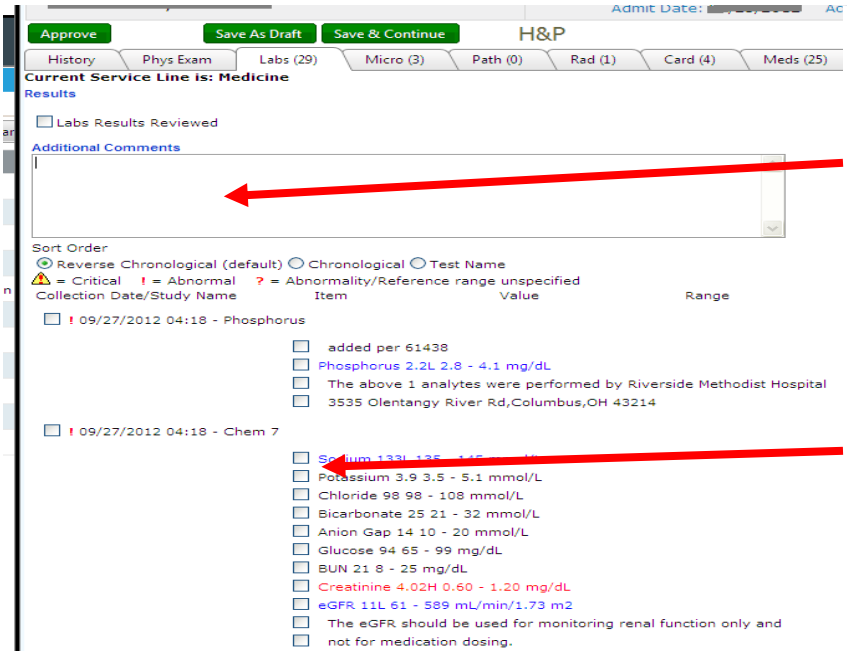
Click **Add New Exam Category** to add an exam category to your My Exam List.

To modify the default normal text, click in the exam text box and update as needed.

Standard and custom exams have a **Hide** option. Selecting Hide removes that exam category from your My Exam List

Use the **dropdowns** next to the exam text to reorder the exam categories.

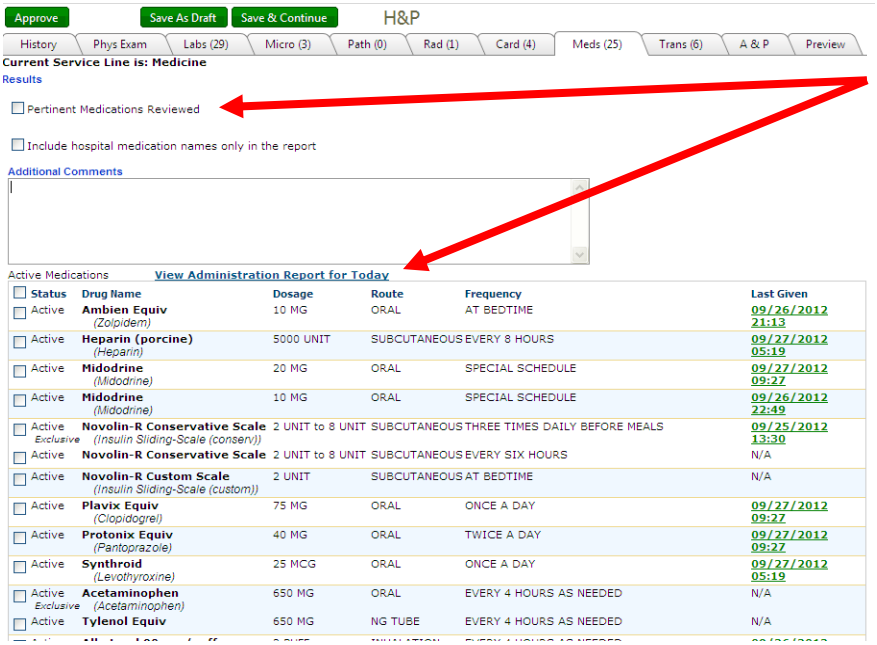
4. The ***Lab, Microbiology, Pathology, Radiology, and Cardiology Tabs*** allow you to review the tab's associated results and enter comments regarding the tests into the note. These tabs will all function in the same manner as below.


Approve
Save As Draft
Save & Continue
H&P
History
Phys Exam
Labs (29)
Micro (3)
Path (0)
Rad (1)
Card (4)
Meds (25)
Current Service Line is: Medicine
Results
Labs Results Reviewed
Additional Comments
Sort Order
Reverse Chronological (default) Chronological Test Name
= Critical ! = Abnormal ? = Abnormality/Reference range unspecified
Collection Date/Study Name
Item
Value
Range
! 09/27/2012 04:18 - Phosphorus
added per 61438
Phosphorus 2.2L 2.8 - 4.1 mg/dL
The above 1 analytes were performed by Riverside Methodist Hospital
3535 Olentangy River Rd,Columbus,OH 43214
! 09/27/2012 04:18 - Chem 7
Potassium 3.9 3.5 - 5.1 mmol/L
Chloride 98 98 - 108 mmol/L
Bicarbonate 25 21 - 32 mmol/L
Anion Gap 14 10 - 20 mmol/L
Glucose 94 65 - 99 mg/dL
BUN 21 8 - 25 mg/dL
Creatinine 4.02H 0.60 - 1.20 mg/dL
eGFR 11L 61 - 589 mL/min/1.73 m2
The eGFR should be used for monitoring renal function only and not for medication dosing.

If all exams in a test tab have been reviewed, you can select Lab Results Reviewed. You can also enter additional comments via the free text box.

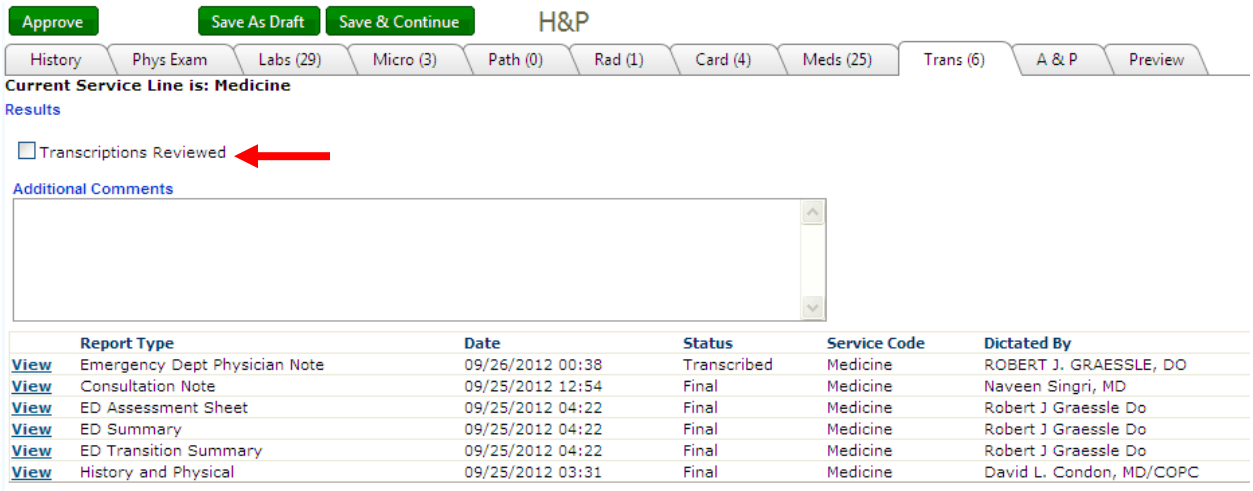
Each Test Tab will also allow you to see the reported results and select only individual results for review documentation.

5. The ***Medications Tab*** lists the patient's current hospital medications.

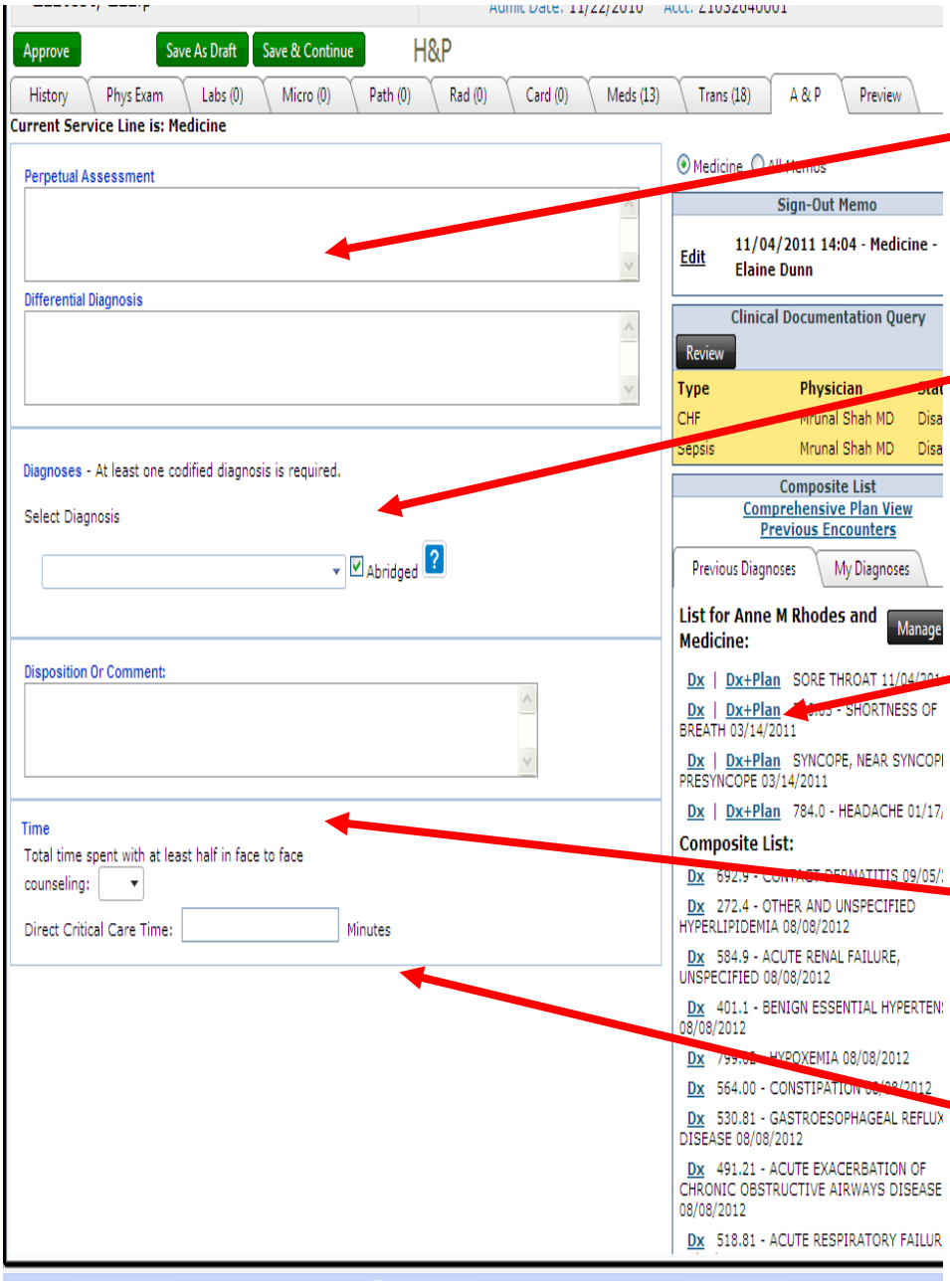

Approve
Save As Draft
Save & Continue
H&P
History
Phys Exam
Labs (29)
Micro (3)
Path (0)
Rad (1)
Card (4)
Meds (25)
Trans (6)
A & P
Preview
Current Service Line is: Medicine
Results
Pertinent Medications Reviewed
Include hospital medication names only in the report
Additional Comments
Active Medications
View Administration Report for Today
Status
Drug Name
Dosage
Route
Frequency
Last Given
Active Ambien Equiv (Zolpidem) 10 MG ORAL AT BEDTIME 09/26/2012 21:13
Active Heparin (porcine) (Heparin) 5000 UNIT SUBCUTANEOUS EVERY 8 HOURS 09/27/2012 05:19
Active Midodrine (Midodrine) 20 MG ORAL SPECIAL SCHEDULE 09/27/2012 09:27
Active Midodrine (Midodrine) 10 MG ORAL SPECIAL SCHEDULE 09/26/2012 22:49
Active Exclusive Novolin-R Conservative Scale (Insulin Sliding-Scale (conserv)) 2 UNIT to 8 UNIT SUBCUTANEOUS THREE TIMES DAILY BEFORE MEALS 09/25/2012 13:30
Active Novolin-R Conservative Scale 2 UNIT to 8 UNIT SUBCUTANEOUS EVERY SIX HOURS N/A
Active Novolin-R Custom Scale (Insulin Sliding-Scale (custom)) 2 UNIT SUBCUTANEOUS AT BEDTIME N/A
Active Plavix Equiv (Clopidogrel) 75 MG ORAL ONCE A DAY 09/27/2012 09:27
Active Protonix Equiv (Pantoprazole) 40 MG ORAL TWICE A DAY 09/27/2012 09:27
Active Synthroid (Levothyroxine) 25 MCG ORAL ONCE A DAY 09/27/2012 05:19
Active Exclusive Acetaminophen (Acetaminophen) 650 MG ORAL EVERY 4 HOURS AS NEEDED N/A
Active Tylenol Equiv 650 MG NG TUBE EVERY 4 HOURS AS NEEDED N/A

You can select Pertinent Medications Reviewed or select individual medications to include in reviewed notes. Additional comments can also be entered for the medications review.

6. The ***Transcriptions Tab*** lists results and reports for the selected encounter. Add a check mark to indicate results have been reviewed. Additional comments on the indicated reports can be entered as well.



7. The ***Assessment and Plan Tab*** allows for entry of the patient's diagnosis and treatment plan.



The Perpetual Assessment is a free text entry box.

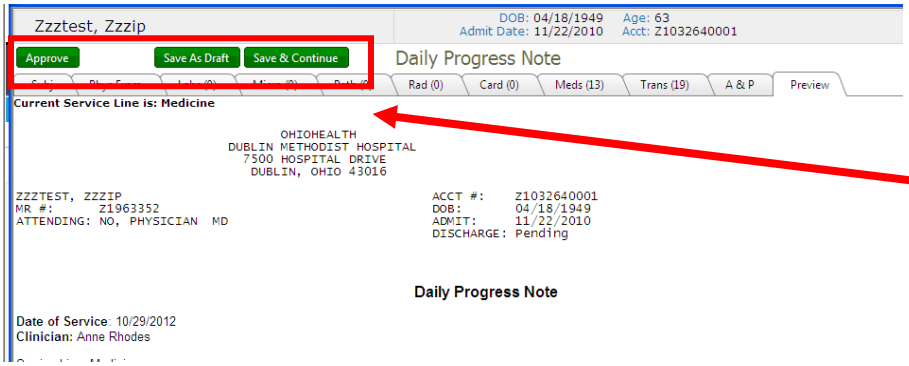
Diagnosis is a required field. All diagnoses entered must be codified. To search by ICD-9 code, select Abridged. You may edit a diagnosis description once the diagnosis code is selected.

Diagnosis and Plans entered previously will display in the Diagnosis List for selection.

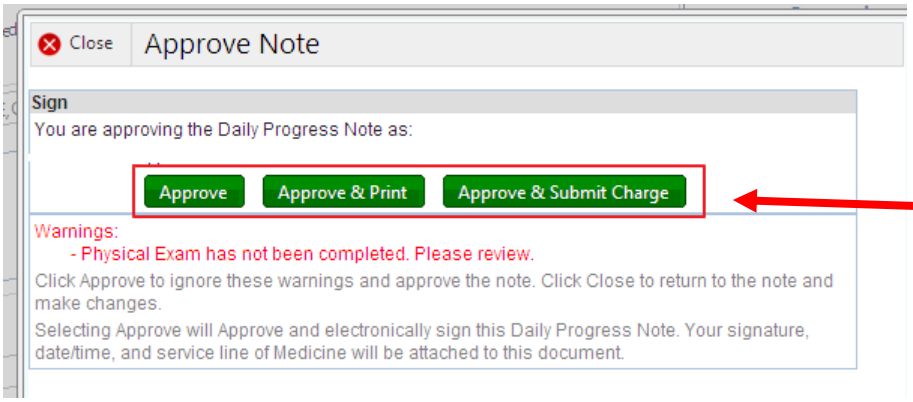
Enter Disposition or comments via free text.

Face to Face counseling and Critical Care time can also be entered via the A&P Tab

8. The ***Preview Tab*** allows you to review and print the note. Once you are satisfied with the note, you can select Approve to finalize and approve the note.



You can choose to Approve the note now, or Save as Draft to complete at a later time.

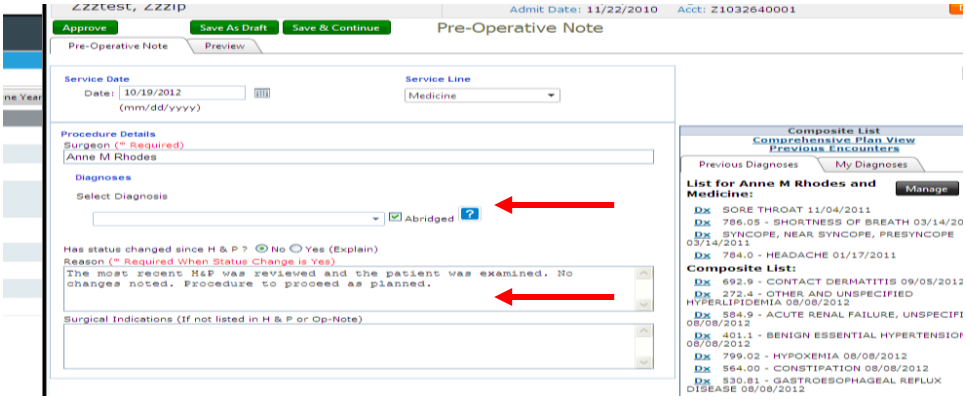

Close
Approve Note
Sign
You are approving the Daily Progress Note as:
Approve
Approve & Print
Approve & Submit Charge
Warnings:
- Physical Exam has not been completed. Please review.
Click Approve to ignore these warnings and approve the note. Click Close to return to the note and make changes.
Selecting Approve will Approve and electronically sign this Daily Progress Note. Your signature, date/time, and service line of Medicine will be attached to this document.

Along with Approving the note, you can Approve & Submit Charges. This will take you into Charge Capture for the patient after the note approval completed

Completing a Preoperative note

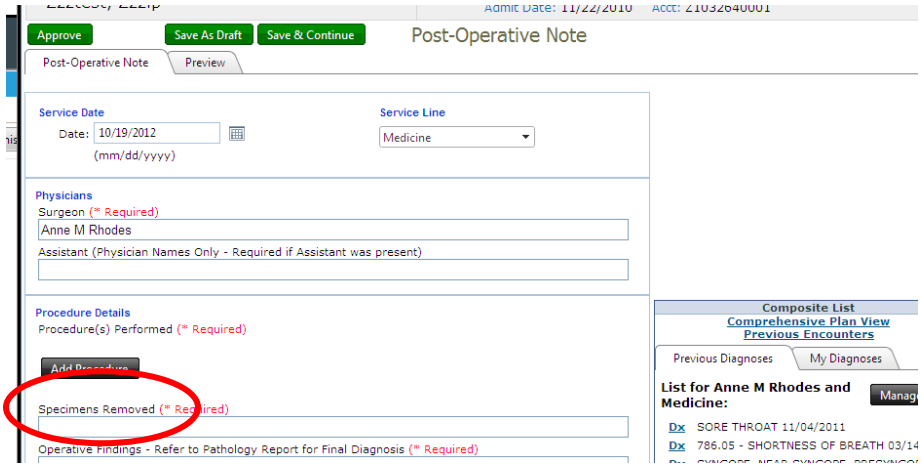
a. Enter a Codified Diagnosis on Pre-Operative Note by typing in Diagnosis box or selecting a diagnosis by clicking on Dx on the Diagnosis List on the right.

b. The H&P status attestation will default to No with pre-formatted text. If there has been a change since the last H&P, select Yes and free text indicated update.

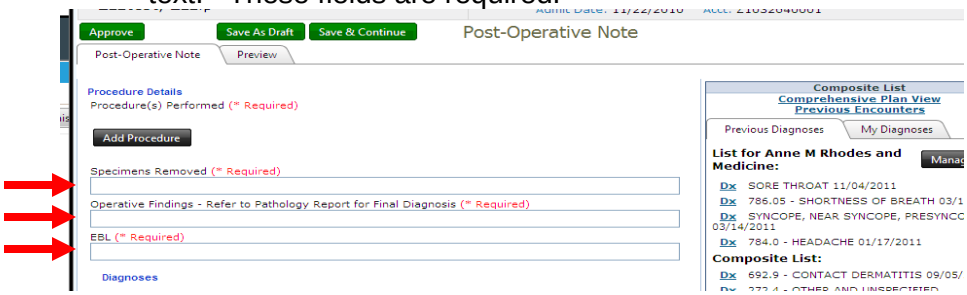

Approve
Save As Draft
Save & Continue
Pre-Operative Note
Pre-Operative Note
Preview
Service Date
Date: 10/19/2012
(mm/dd/yyyy)
Service Line
Medicine
Procedure Details
Surgeon (* Required)
Anne M Rhodes
Diagnoses
Select Diagnosis
Abridged
Has status changed since H & P ? No Yes (Explain)
Reason (* Required When Status Change is Yes)
The most recent H&P was reviewed and the patient was examined. No changes noted. Procedure to proceed as planned.
Surgical Indications (If not listed in H & P or Op-Note)
Composite List
Comprehensive Plan View
Previous Encounters
Previous Diagnoses
My Diagnoses
List for Anne M Rhodes and Medicine:
Manage
Dx SORE THROAT 11/04/2011
Dx 786.05 - SHORTNESS OF BREATH 03/14/20
Dx SYNCOPE, NEAR SYNCOPE, PRESYNCOPE 03/14/2011
Dx 784.0 - HEADACHE 01/17/2011
Composite List:
Dx 692.9 - CONTACT DERMATITIS 09/05/2012
Dx 272.4 - OTHER AND UNSPECIFIED HYPERLIPIDEMIA 08/08/2012
Dx 584.9 - ACUTE RENAL FAILURE, UNSPECIFI 08/08/2012
Dx 401.1 - BENIGN ESSENTIAL HYPERTENSION 08/08/2012
Dx 799.02 - HYPOXEMIA 08/08/2012
Dx 564.00 - CONSTIPATION 08/08/2012
Dx 530.81 - GASTROESOPHAGEAL REFLUX DISEASE 08/08/2012

Completing a Postoperative note

1. Click **Add Procedure** and enter procedure name in text box.



2. Complete the Specimens Removed, Operative Findings, and EBL fields by entering free text. These fields are required.

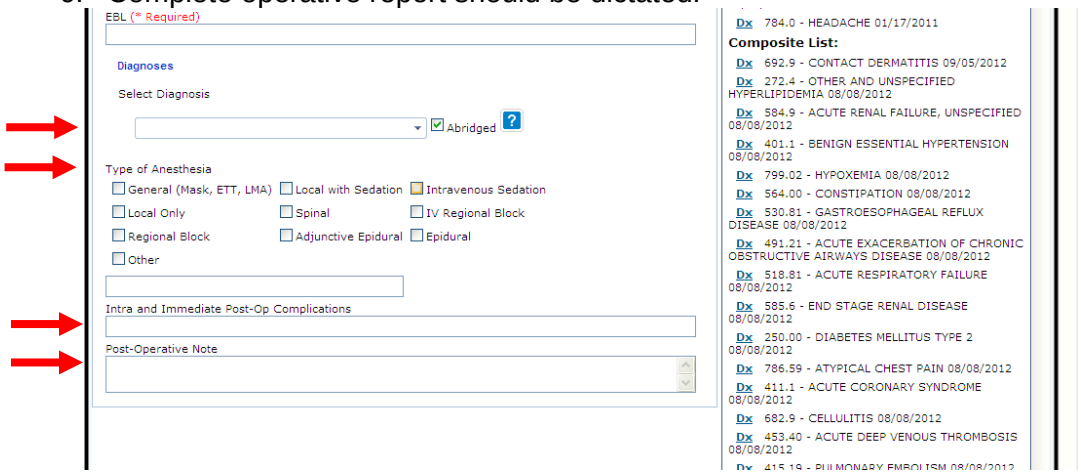


3. Complete Diagnosis field by choosing a documented diagnosis on the right or by typing a codified diagnosis code or description.

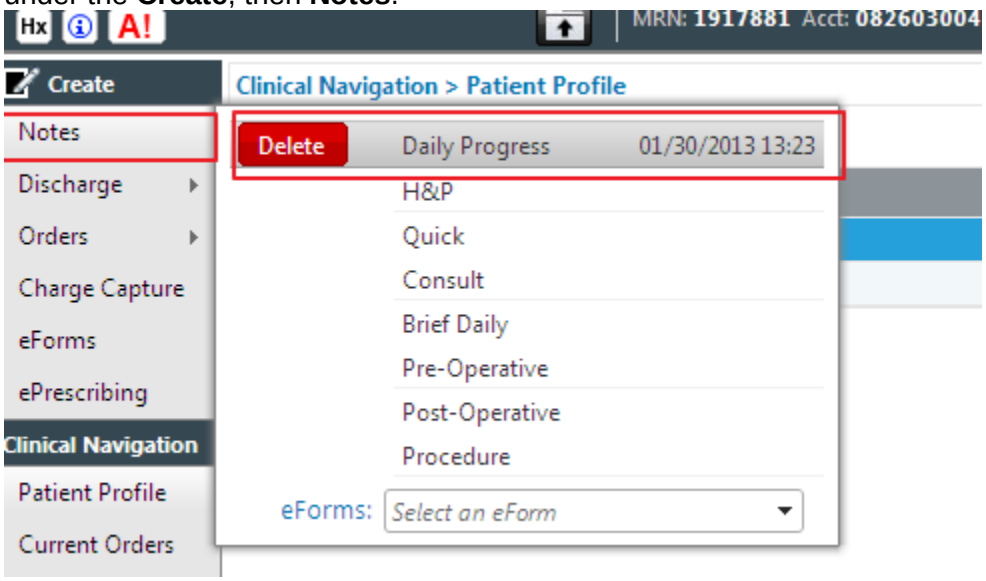
4. Check mark type of anesthesia utilized for procedure.

5. Intra and Immediate Post Op Complications and Post Operative Note are free text fields.

6. Complete operative report should be dictated.


EBL (* Required)
Diagnoses
Select Diagnosis
Abridged
Type of Anesthesia
General (Mask, ETT, LMA)
Local with Sedation
Intravenous Sedation
Local Only
Spinal
IV Regional Block
Regional Block
Adjunctive Epidural
Epidural
Other
Intra and Immediate Post-Op Complications
Post-Operative Note
Dx 784.0 - HEADACHE 01/17/2011
Composite List:
Dx 692.9 - CONTACT DERMATITIS 09/05/2012
Dx 272.4 - OTHER AND UNSPECIFIED HYPERLIPIDEMIA 08/08/2012
Dx 584.9 - ACUTE RENAL FAILURE, UNSPECIFIED 08/08/2012
Dx 401.1 - BENIGN ESSENTIAL HYPERTENSION 08/08/2012
Dx 799.02 - HYPOXEMIA 08/08/2012
Dx 564.00 - CONSTIPATION 08/08/2012
Dx 530.81 - GASTROESOPHAGEAL REFLUX DISEASE 08/08/2012
Dx 491.21 - ACUTE EXACERBATION OF CHRONIC OBSTRUCTIVE AIRWAYS DISEASE 08/08/2012
Dx 518.81 - ACUTE RESPIRATORY FAILURE 08/08/2012
Dx 585.6 - END STAGE RENAL DISEASE 08/08/2012
Dx 250.00 - DIABETES MELLITUS TYPE 2 08/08/2012
Dx 786.59 - ATYPICAL CHEST PAIN 08/08/2012
Dx 411.1 - ACUTE CORONARY SYNDROME 08/08/2012
Dx 682.9 - CELLULITIS 08/08/2012
Dx 453.40 - ACUTE DEEP VENOUS THROMBOSIS 08/08/2012

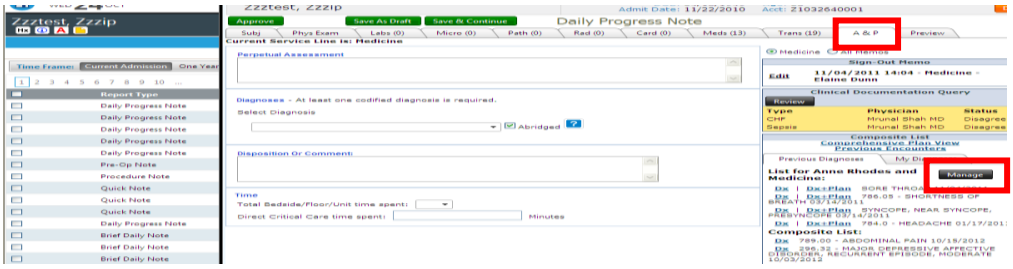
d. If you have chosen to Save as Draft or toggle, the unapproved note will show under the **Create**, then **Notes**.



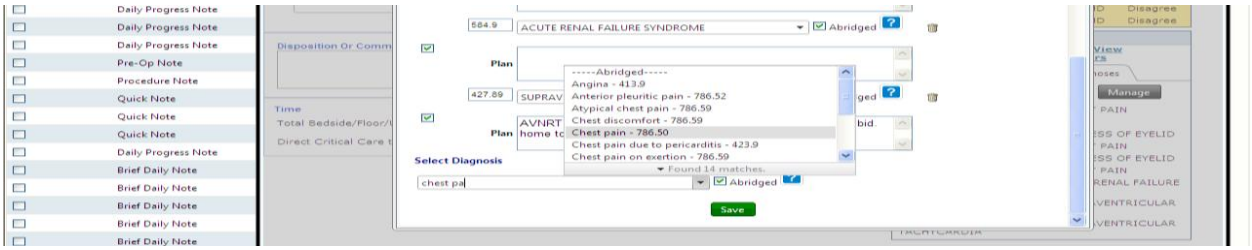
e. Select the Notes button to approve or delete the note.
f. From this screen, you can choose to edit the existing note by clicking on the name of the note or delete the note completely.

My Diagnosis (Codified Diagnosis Tool)

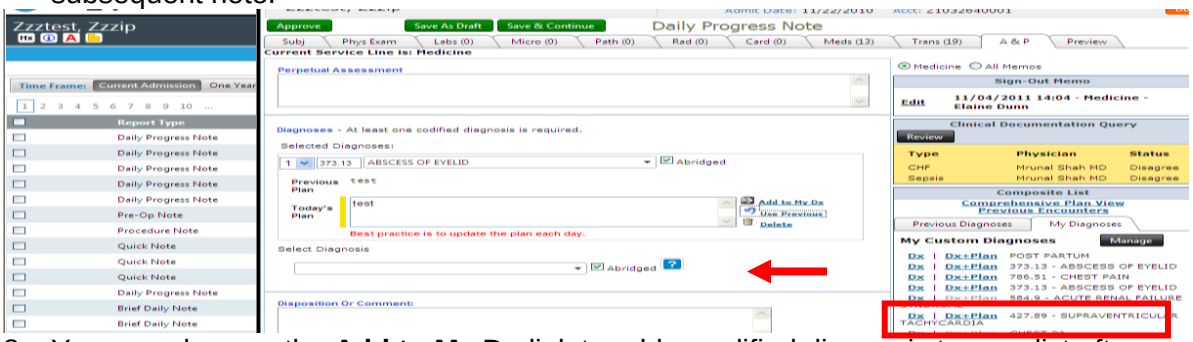
1. Create a Daily Progress Note, Brief Daily, H&P or Consult note in ORB.
2. Select the **A&P Tab**.
3. Select the **My Diagnosis** tab.
4. Select **Manage.**



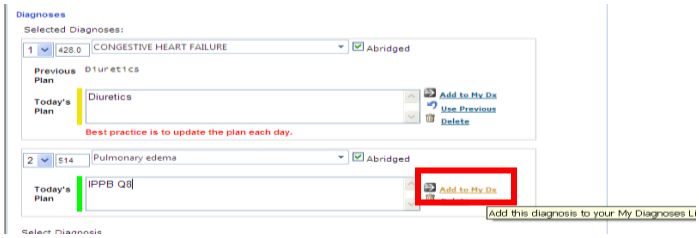
5. Enter the desired Codified Diagnosis in that field. You may enter text and select a provided diagnosis or you may enter the ICD-9 code.



6. Once a codified diagnosis has been entered, you may also modify the description and/or enter a plan that will be saved with that diagnosis.
7. Once you have created a codified diagnosis and plan, click Dx + Plan to enter it in any subsequent note.



8. You can also use the **Add to My Dx** link to add a codified diagnosis to your list after you have created it in your note.

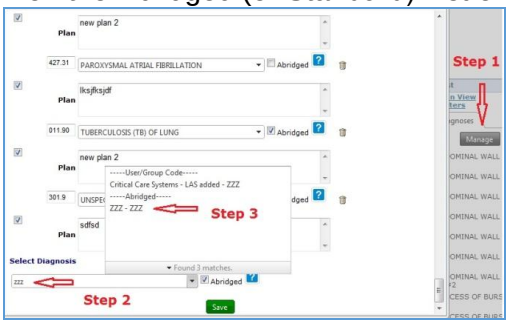


SAVING NON- DIAGNOSIS BASED PLANS IN THE "MY DIAGNOSES" LIST:

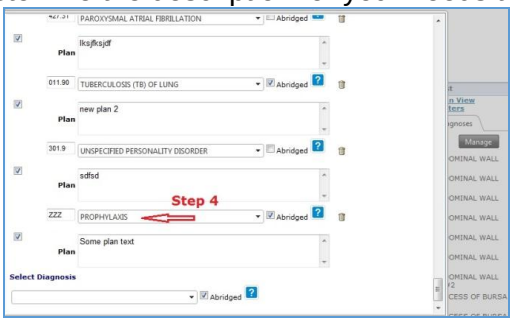
This feature is <u>only</u> to be used for non-diagnosis based plans, for example:

- AAOS Statement for VTE Prophylaxis
- Critical Care Assessment
- Discharge Exam – Well
- Follow Up Exam – Formula Fed
- Prophylaxis
- Nutrition

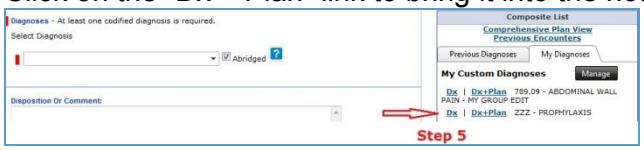
1. In Progress Notes, go to the "My Diagnoses" tab and click the Manage button
2. Search for the term "ZZZ"
3. Click on the Abridged (or Standard) List entry for "ZZZ"



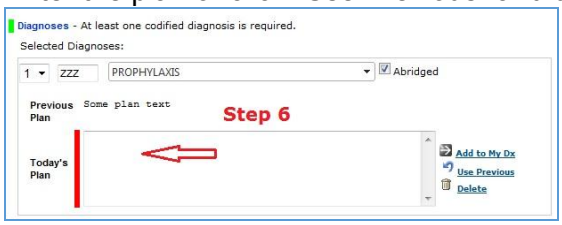
4. Customize the description for your needs then click the **Save** button:



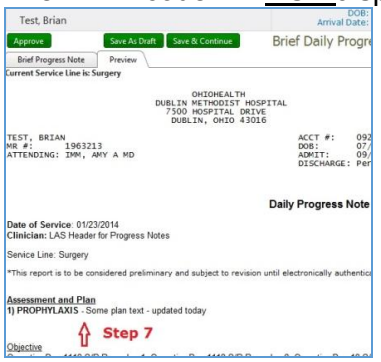
5. Click on the "Dx + Plan" link to bring it into the note:



6. Enter the plan or click "Use Previous" and update the previous plan:

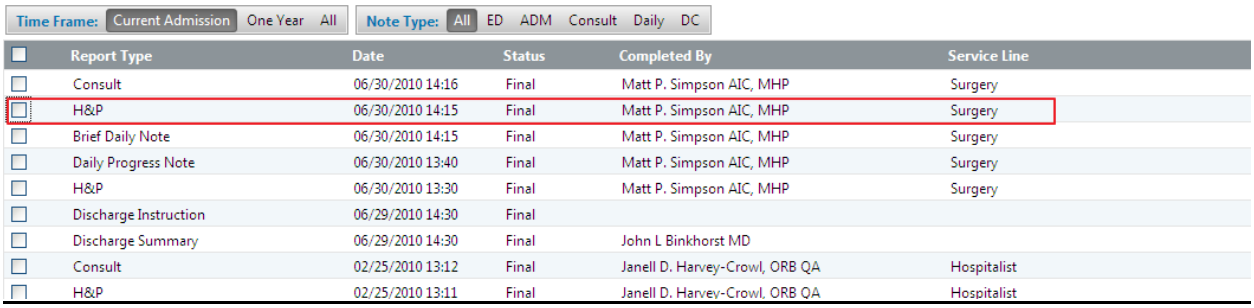


7. The “ZZZ” code will NOT display on the report:

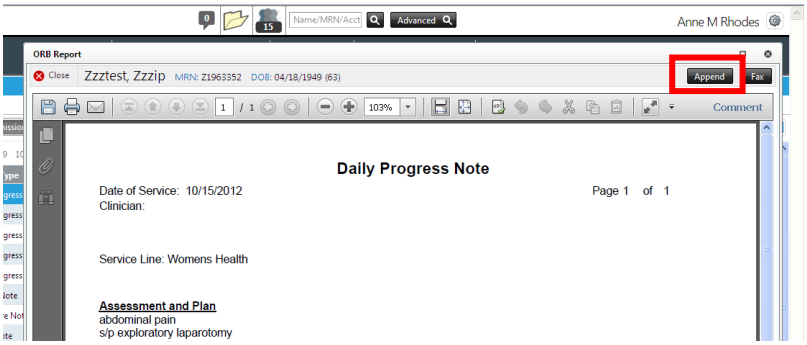


Appending a Note

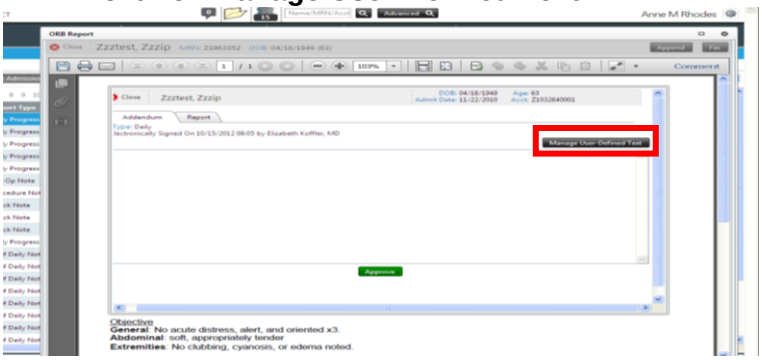
1. When logged into ORB and in the patient's record, **select note** that you would like to Append.


Time Frame: Current Admission One Year All
Note Type: All ED ADM Consult Daily DC
Report Type | Date | Status | Completed By | Service Line
Consult | 06/30/2010 14:16 | Final | Matt P. Simpson AIC, MHP | Surgery
H&P | 06/30/2010 14:15 | Final | Matt P. Simpson AIC, MHP | Surgery
Brief Daily Note | 06/30/2010 14:15 | Final | Matt P. Simpson AIC, MHP | Surgery
Daily Progress Note | 06/30/2010 13:40 | Final | Matt P. Simpson AIC, MHP | Surgery
H&P | 06/30/2010 13:30 | Final | Matt P. Simpson AIC, MHP | Surgery
Discharge Instruction | 06/29/2010 14:30 | Final
Discharge Summary | 06/29/2010 14:30 | Final | John L Binkhorst MD
Consult | 02/25/2010 13:12 | Final | Janell D. Harvey-Crowl, ORB QA | Hospitalist
H&P | 02/25/2010 13:11 | Final | Janell D. Harvey-Crowl, ORB QA | Hospitalist

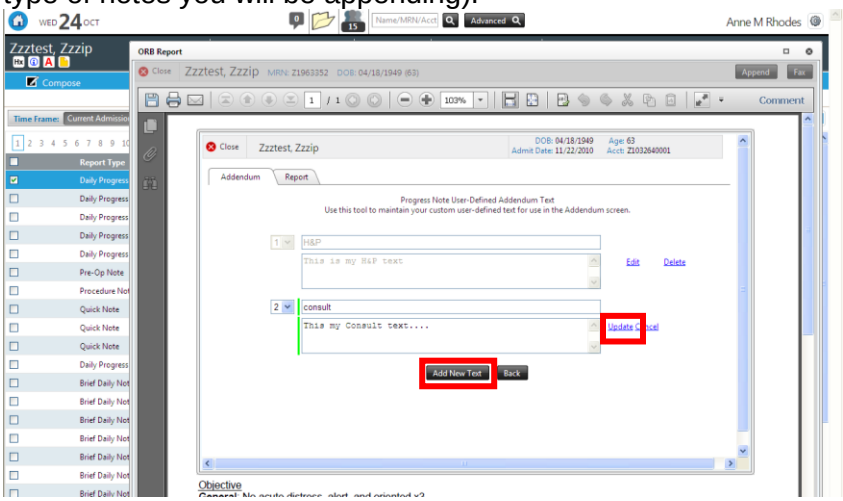
1. The note will open. Click the **Append** button.



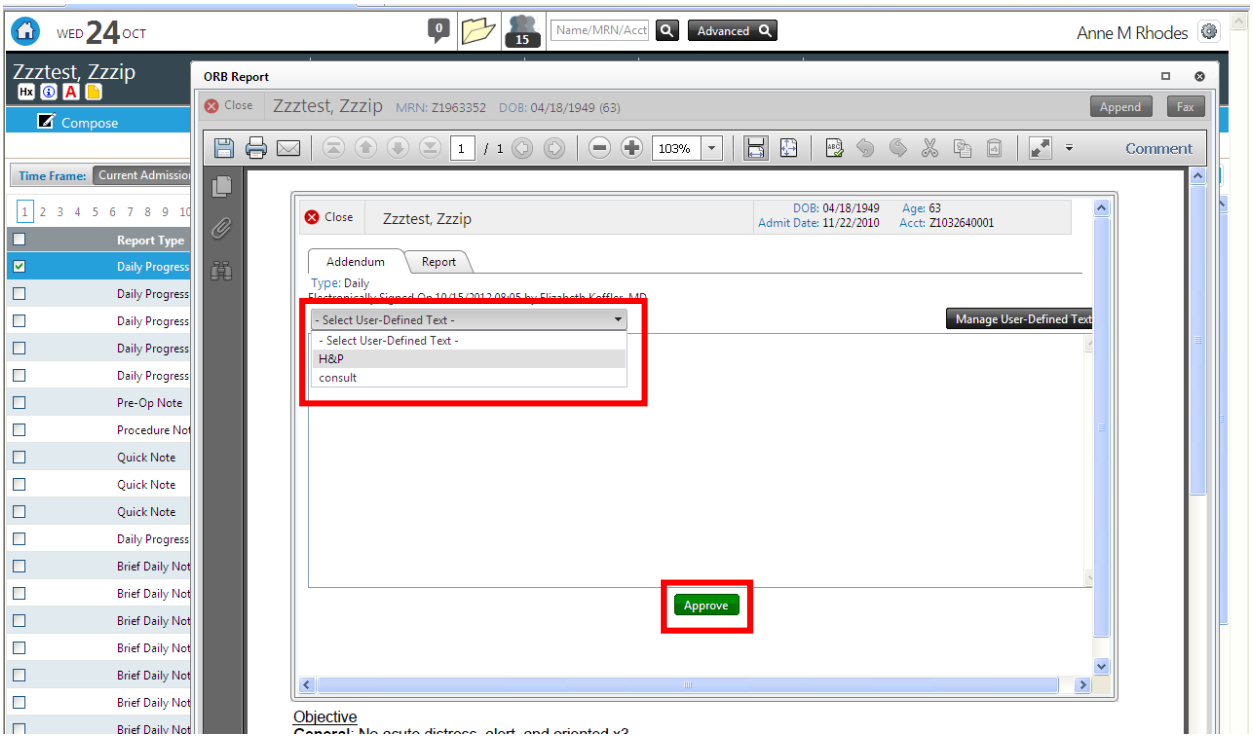
2. Click on **Manage User-Defined Text**.



3. Create your user defined text (This is where you can create your multiple phrases for the type of notes you will be appending).



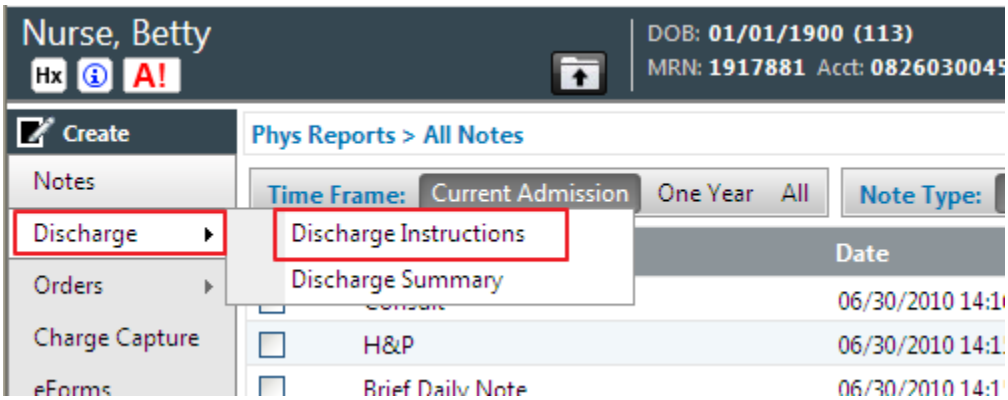
4. Click **Update** when ready to save. To add additional user define text options select **Add New Text.**
5. Click **Select User-Defined text** to add text.
6. Edit text within box.



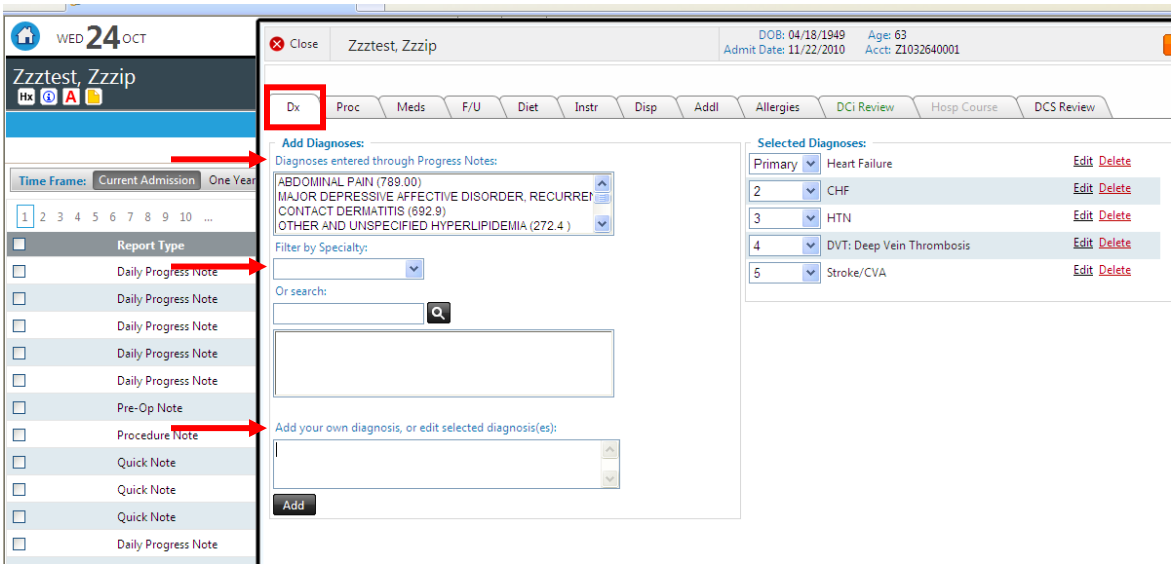
7. Click on **Approve** when finished.

Completing the Discharge Instructions

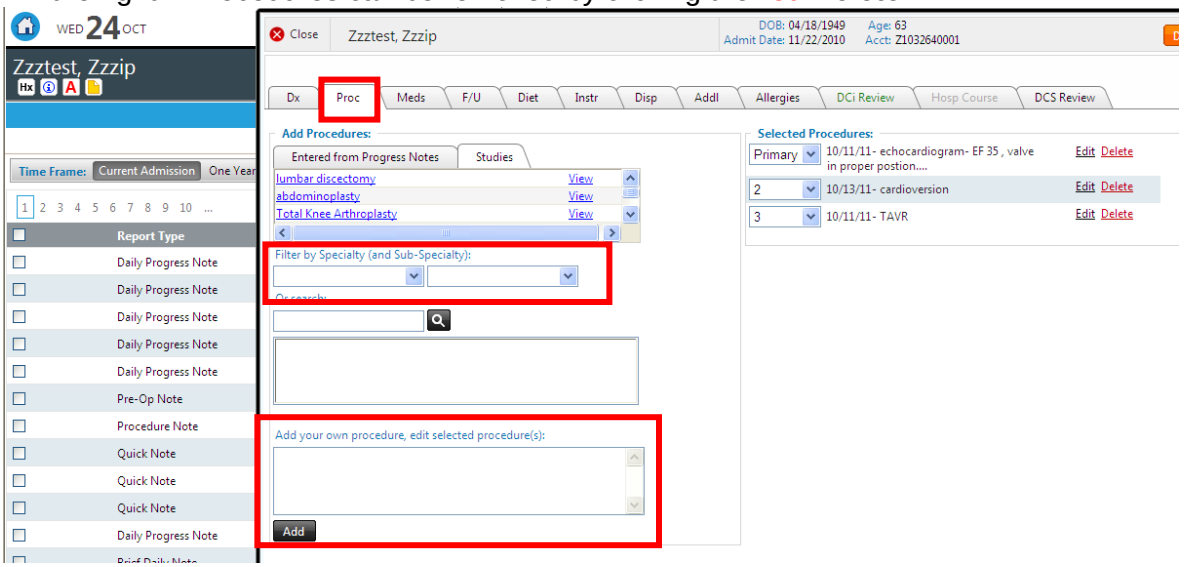
1. Under the **Create** menu, select **Discharge**, select Discharge Instructions.



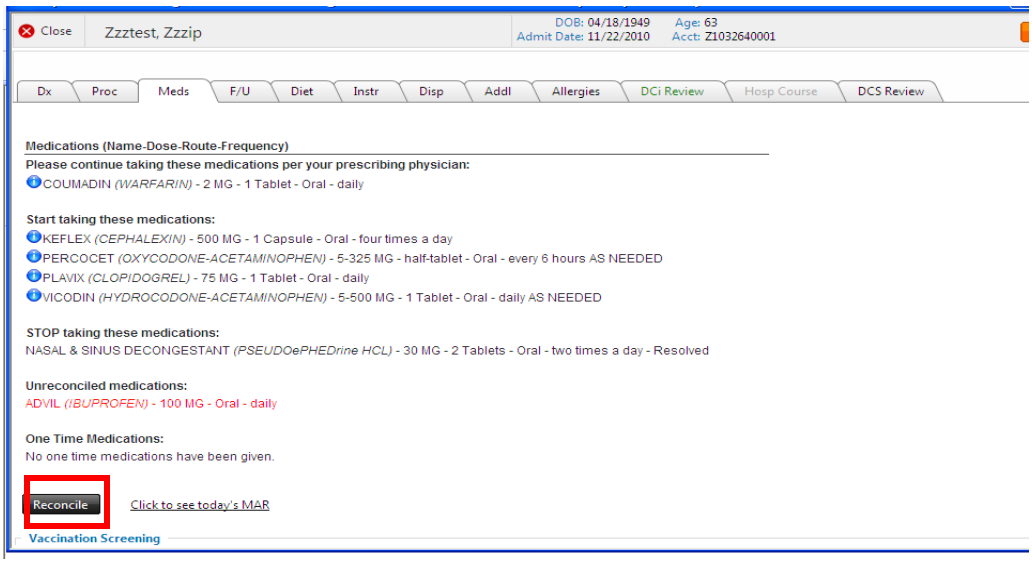
2. The **Dx** tab will list any diagnoses completed in ORB documentation. Select to add a diagnosis to the patient's discharge instructions by clicking on the diagnosis. You can also search for procedures by selecting the filter drop down. Finally, you can enter additional diagnosis by typing your selection in the bottom text box. Diagnosis' that have been added will be displayed on the right side.



3. Add **Procedures** performed during this encounter. You can select a procedure from the specialty filters or enter you own. Procedures selected will be added to the patient list on the right. Procedures can be removed by clicking the **red Delete** link.



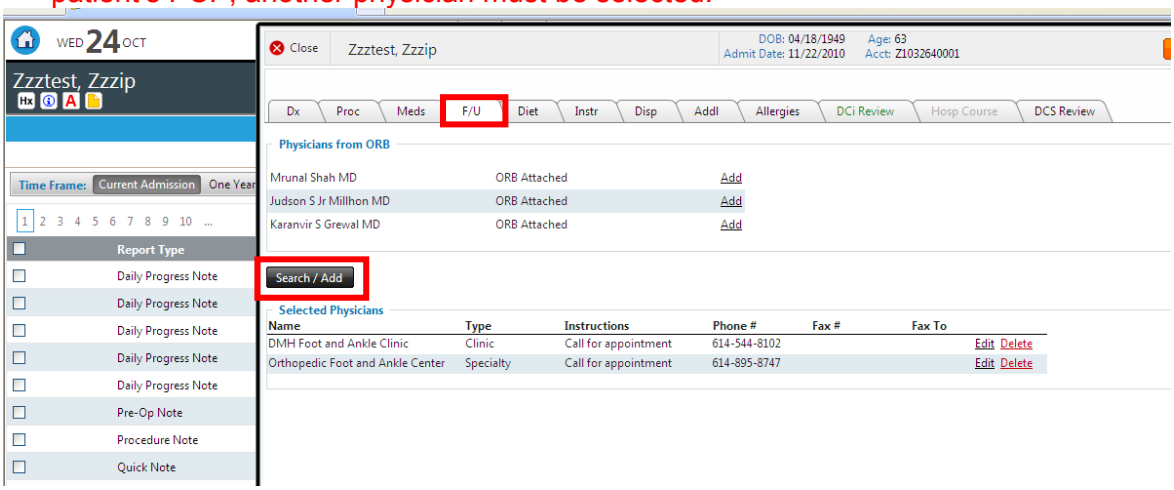
4. The **Meds** tab contains home and hospital medications that must be reconciled prior to discharge. Click **Reconcile** to create the patient's discharge medications.


Close
Zzztest, Zzip
DOB: 04/18/1949
Admit Date: 11/22/2010
Age: 63
Acct: Z1032640001
Dx
Proc
Meds
F/U
Diet
Instr
Disp
Addl
Allergies
DCi Review
Hosp Course
DCS Review
Medications (Name-Dose-Route-Frequency)
Please continue taking these medications per your prescribing physician:
COUMADIN (WARFARIN) - 2 MG - 1 Tablet - Oral - daily
Start taking these medications:
KEFLEX (CEPHALEXIN) - 500 MG - 1 Capsule - Oral - four times a day
PERCOCET (OXYCODONE-ACETAMINOPHEN) - 5-325 MG - half-tablet - Oral - every 6 hours AS NEEDED
PLAVIX (CLOPIDOGREL) - 75 MG - 1 Tablet - Oral - daily
VICODIN (HYDROCODONE-ACETAMINOPHEN) - 5-500 MG - 1 Tablet - Oral - daily AS NEEDED
STOP taking these medications:
NASAL & SINUS DECONGESTANT (PSEUDOePHEDrine HCL) - 30 MG - 2 Tablets - Oral - two times a day - Resolved
Unreconciled medications:
ADVIL (IBUPROFEN) - 100 MG - Oral - daily
One Time Medications:
No one time medications have been given.
Reconcile
Click to see today's MAR
Vaccination Screening

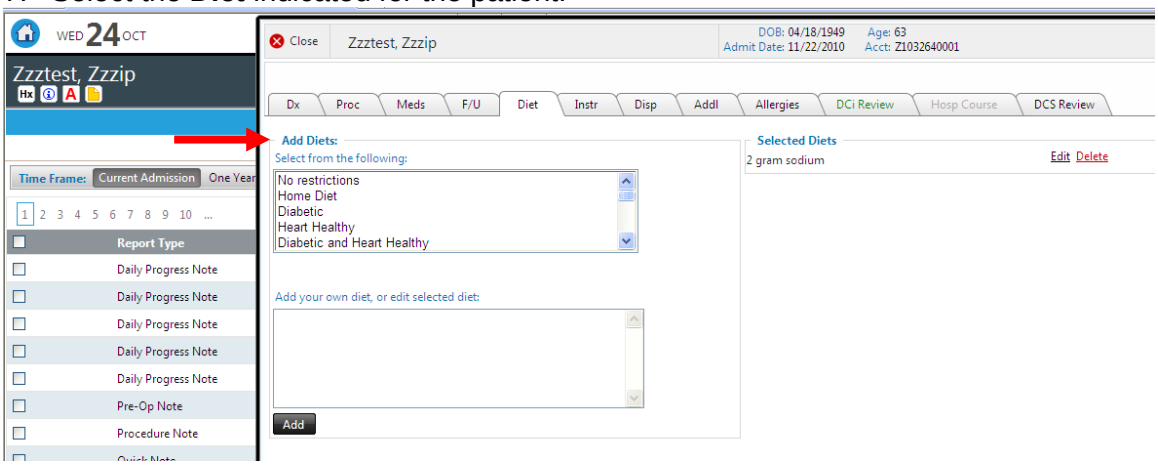
5. Home medications will show in the top left hand side. If the patient had continued that medication in house, the medication will display to the right of the home medication. Hospital only medications will display in the bottom right hand side. For each medication, select the appropriate option: **Continue, Change, Stop or Start Taking.** When complete, select **Close.**

Close
Zzztest, Zzzip
DOB: 04/18/1949 Age: 63
Admit Date: 11/22/2010 Acct: Z1032640001
ORB
Add Home Medication
Add Discharge Medication
Print Preview
Refresh Screen
Medications To Reconcile
Matched Hospital Medications
Continue Taking
Continue Change Stop
Edit Home Med Delete Reset
ADVIL 100 MG Oral daily
(IBUPROFEN) Charted By: Anne M Rhodes
Continue Taking
COUMADIN 2 MG 1 Tablet Oral daily
(WARFARIN) Charted By: Thomas J Gavin, MD
Start Taking
Edit Discharge Med Delete
KEFLEX 500 MG 1 Capsule Oral four times a day
(CEPHALEXIN) Charted By: Sarah L Liegl, PA
Stop Taking
NASAL & SINUS DECONGESTANT 30 MG 2 Tablets Oral two times a day
(PSEUDOePHEDrine HCL) Charted By: Bradley A Bryan, MD
Discontinued: Resolved (Edit)
PERCOCET 5-325 MG half-tablet Oral every 6 hours As Needed
(OXYCODONE-ACETAMINOPHEN) Charted By: Thomas K Hunt
POSSIBLE DUPLICATE MEDICATION!
VICODIN 5-500 MG 1 Tablet Oral daily As Needed
(HYDROCODONE-ACETAMINOPHEN) Charted By: Karen L. Hall
POSSIBLE DUPLICATE MEDICATION!
PLAVIX 75 MG 1 Tablet Oral daily

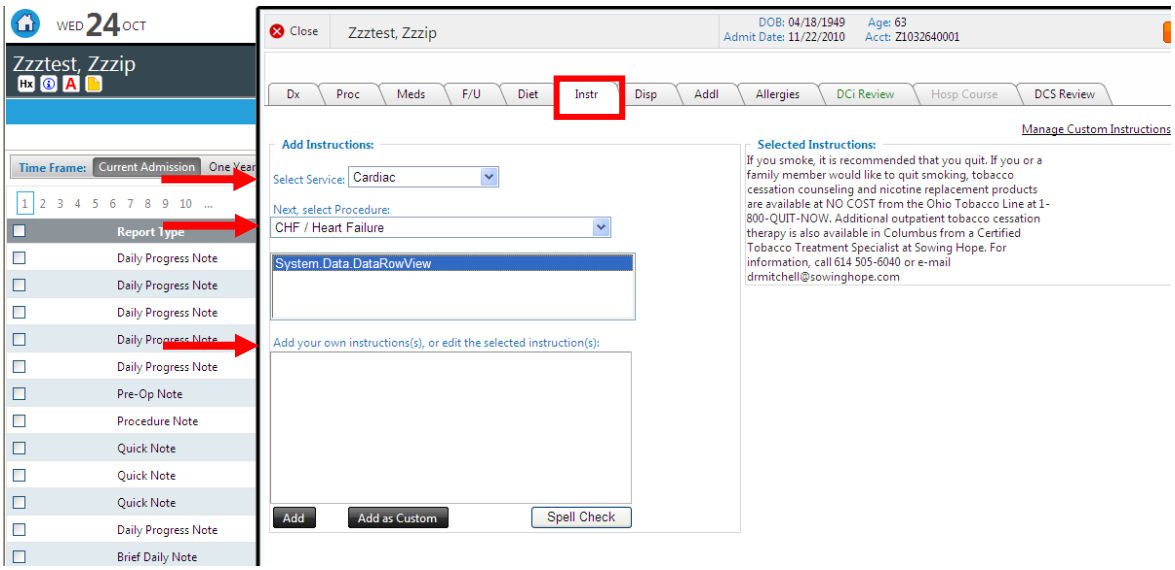
6. The **Follow –Up** tab allows you to enter follow up instructions with the physicians contact information. Click **Search / Add** to add additional physicians. Note: The patient's Primary Care Physician (PCP) is automatically selected if assigned by STAR. To remove the patient's PCP, another physician must be selected.


WED 24 OCT
Zzztest, Zzzip
Time Frame: Current Admission One Year
Report Type
Daily Progress Note
Pre-Op Note
Procedure Note
Quick Note
Close
Zzztest, Zzzip
DOB: 04/18/1949 Age: 63
Admit Date: 11/22/2010 Acct: Z1032640001
Dx Proc Meds F/U Diet Instr Disp Addl Allergies DCi Review Hosp Course DCS Review
Physicians from ORB
Mrunal Shah MD ORB Attached Add
Judson S Jr Millhon MD ORB Attached Add
Karanvir S Grewal MD ORB Attached Add
Search / Add
Selected Physicians
Name Type Instructions Phone # Fax # Fax To
DMH Foot and Ankle Clinic Clinic Call for appointment 614-544-8102 Edit Delete
Orthopedic Foot and Ankle Center Specialty Call for appointment 614-895-8747 Edit Delete

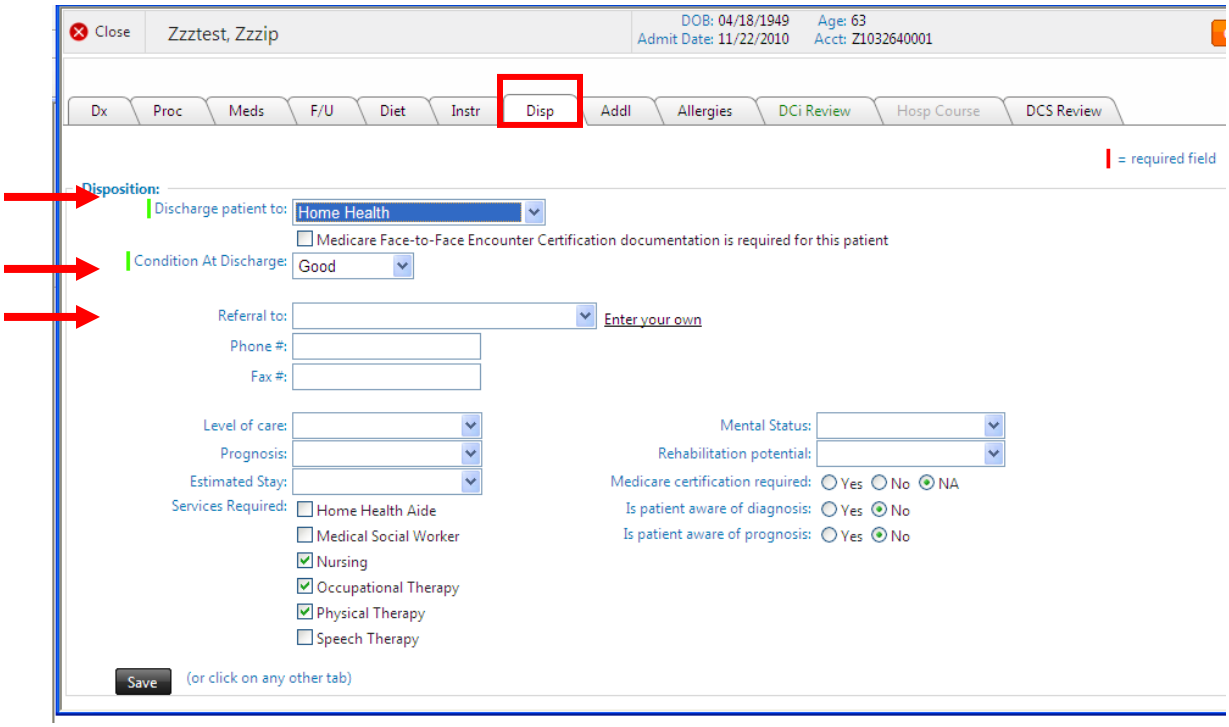
7. Select the **Diet** indicated for the patient.



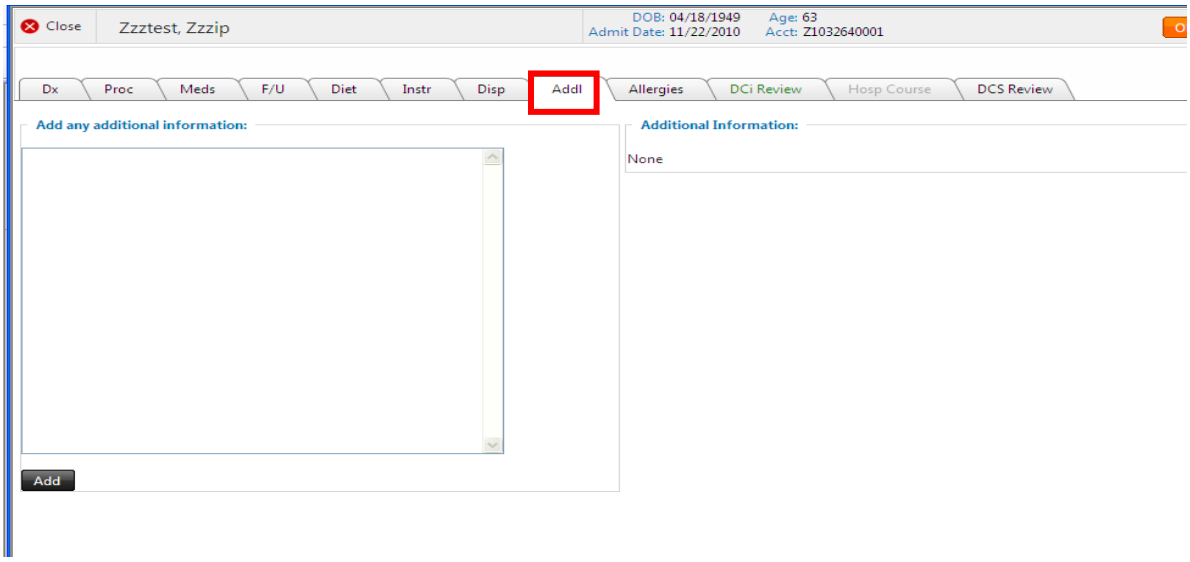
8. The **Instructions** tab allows for entry of standard and custom care instructions. Select the service line then procedure to add standard instructions. Additional instructions can be entered using the text box. You can create custom instructions for future use by selecting Save as Custom after entering your text. Remove unwanted instructions by selecting the **red Delete** link.



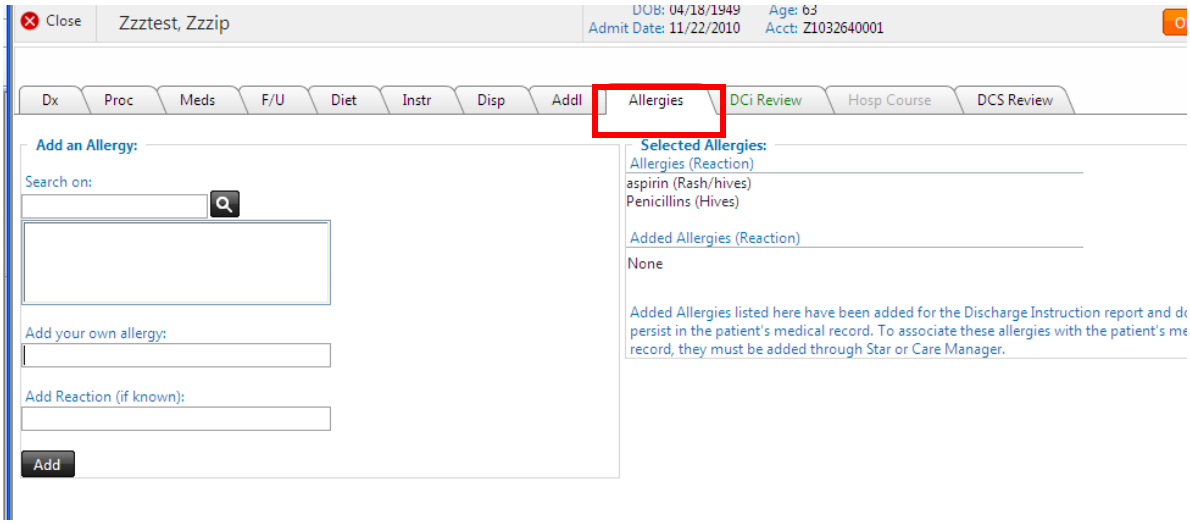
9. The **Disp** tab allows for entry of disposition information. Select the location the patient is being discharged to. Select the Condition at discharge. The Medicare Face to Face Encounter box should be checked for any home health patients. Referral to a post-acute provider can be entered as indicated.



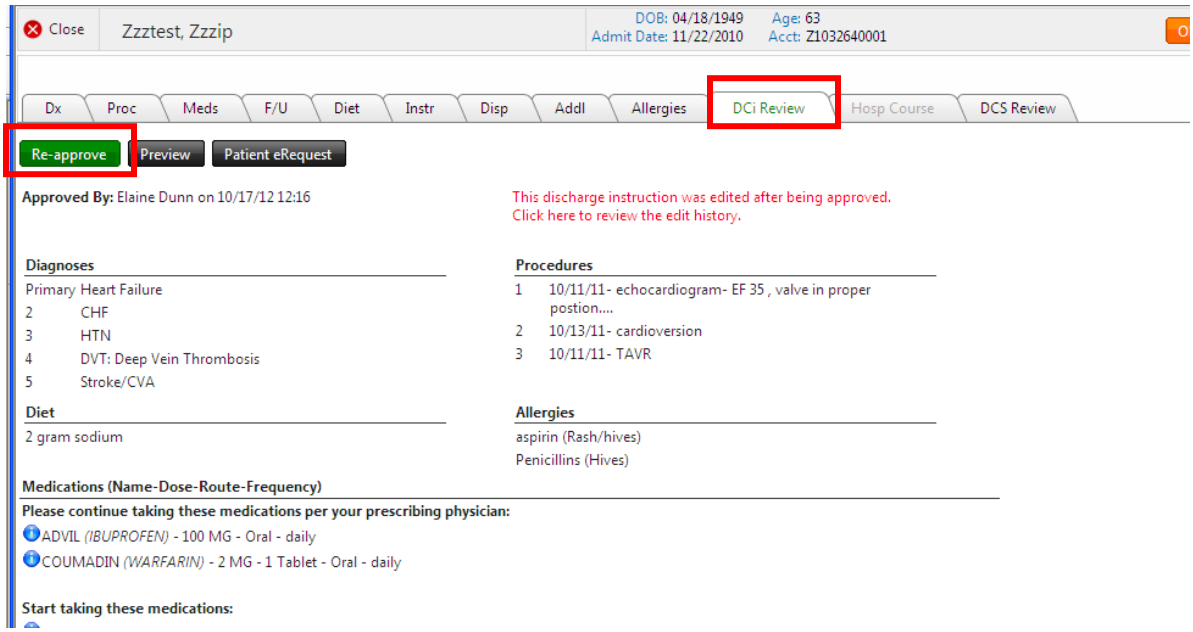
10. The **Addl** tab allows for free text entry of any additional information you would like to include on the Discharge Instructions.



11. Allergies previously documented will cross over automatically to the Discharge Instructions. Additional allergies can added if indicated.

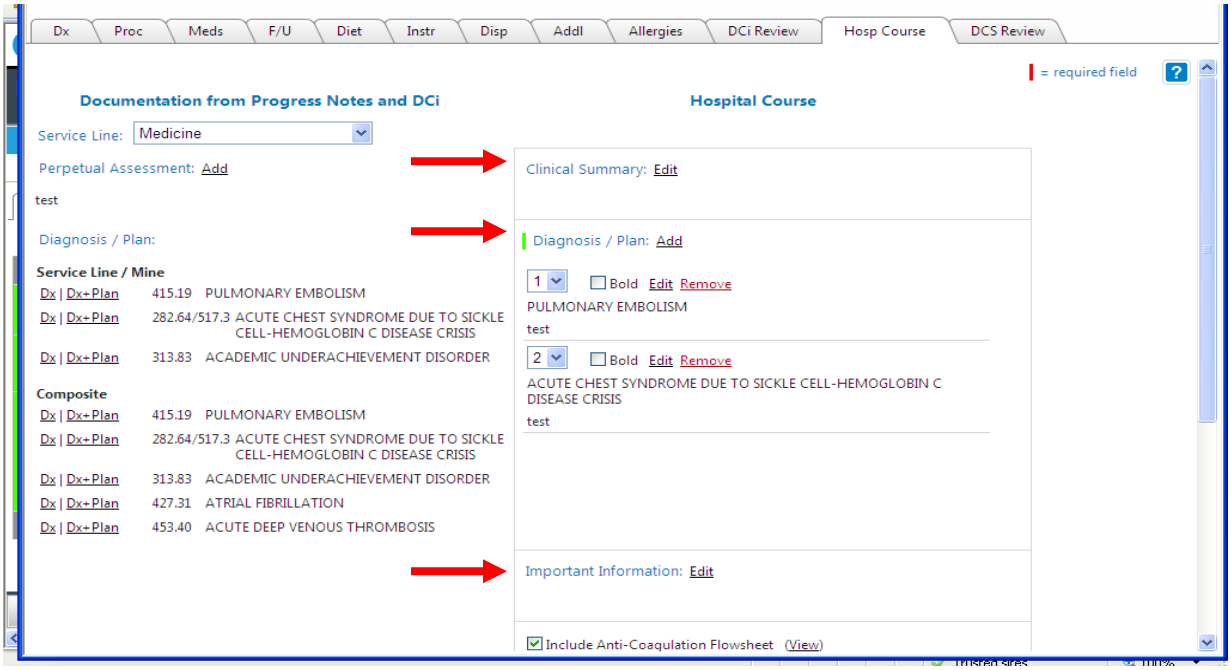


12. The **DCi Review** tab allows for preview of the final instructions. Physicians must approve the DCi by selecting the green **Approve** button. **Green** DCi Review means the DCi has been approved.

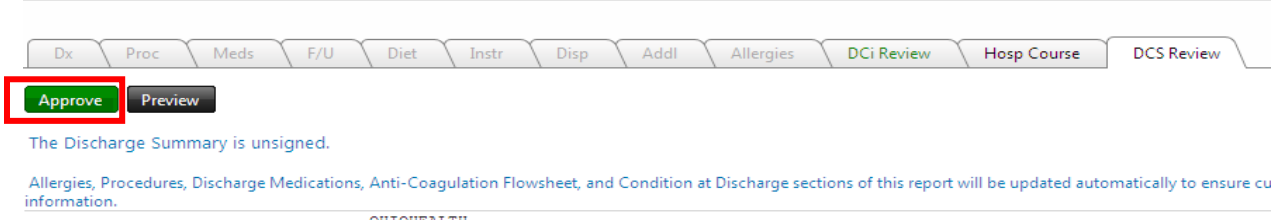


Completing the Discharge Summaries

1. Under the **Create** menu, select **Discharge**, then Discharge Summary.
2. **Clinical Summary**: Perpetual Assessment from previous notes can be used or click Edit to enter additional text.
3. **Diagnosis / Plan**: Previously documented diagnosis' and plans can be utilized by clicking the Dx or Dx+Plan on the left.
4. **Important Information**: Click Edit to enter any indicated text.
5. **Diet**: Click to add the Diet entered in the Discharge Instructions.
6. **Additional Comments**: Click Edit to enter indicated text.
7. **Time Spent on Discharge**: select 30 minutes or less radio button or slect the 30 minutes or more radio button.

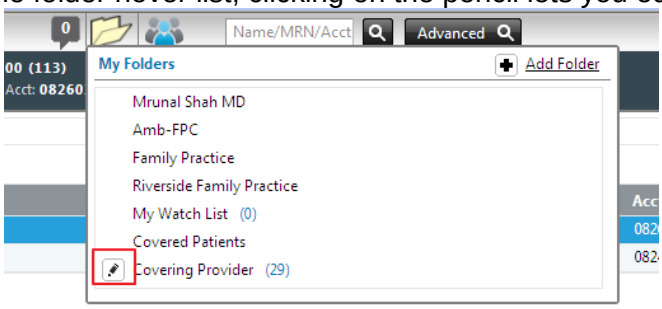


8. To approve the Discharge Summary, select the **DCS Review** tab and select **Approve**.

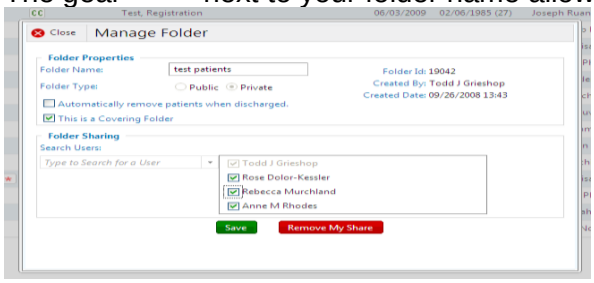


Editing and Creating Folders in ORB

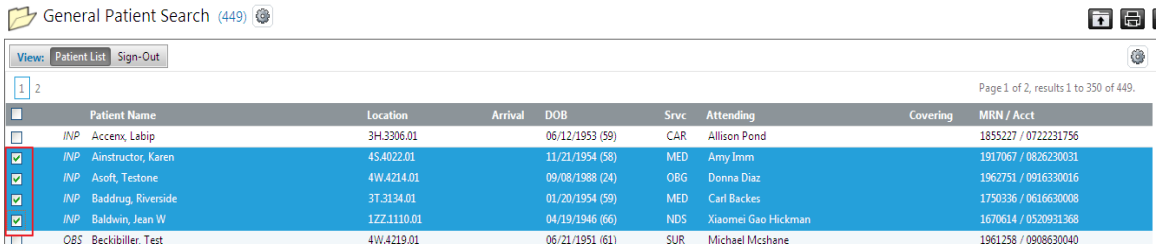
1. To edit any folders you can hover over the **Show Folder** icon. A list of all your folders will appear in the dropdown. There is a pencil icon beside editable folders in the folder hover list, clicking on the pencil lets you edit the folder.



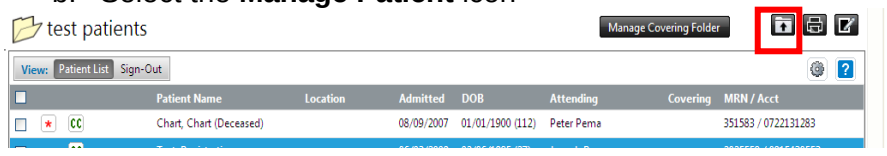
2. The gear next to your folder name allows you to edit the folder



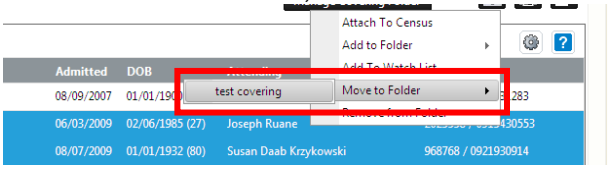
3. To move patient from one folder to another folder
   a. Select the box next the patients name you wish to move


General Patient Search (449)
View: Patient List Sign-Out
Page 1 of 2, results 1 to 350 of 449.
Patient Name
Location
Arrival
DOB
Srvc
Attending
Covering
MRN / Acct
INP Accenx, Labip 3H.3306.01 06/12/1953 (59) CAR Allison Pond 1855227 / 0722231756
INP Ainstructor, Karen 4S.4022.01 11/21/1954 (58) MED Amy Imm 1917067 / 0826230031
INP Asoft, Testone 4W.4214.01 09/08/1988 (24) OBG Donna Diaz 1962751 / 0916330016
INP Baddrug, Riverside 3T.3134.01 01/20/1954 (59) MED Carl Backes 1750336 / 0616630008
INP Baldwin, Jean W 1ZZ.1110.01 04/19/1946 (66) NDS Xiaomei Gao Hickman 1670614 / 0520931368
OBS Beckibiller. Test 4W.4219.01 06/21/1951 (61) SUR Michael Mcshane 1961258 / 0908630040

   b. Select the **Manage Patient** icon

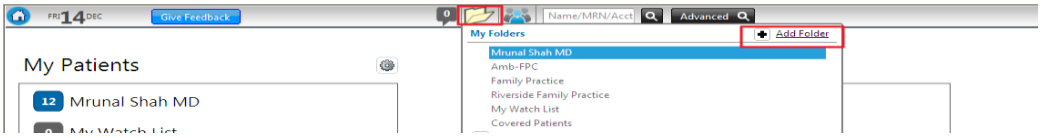


   c. Select Move to a folder, then the folder's name

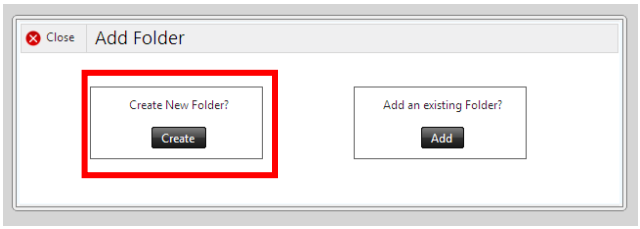


   d. The patients are now listed in the selected folder

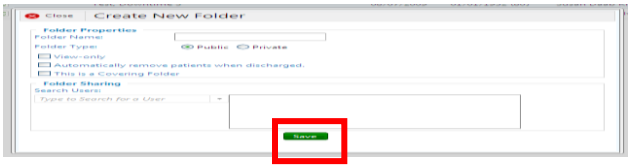
4. To create a new folder
   a. Select the add folder icon on the top header of the screen, then select **Add Folder**



   b. Select the create button under create new folder



   c. Enter the name of the folder in Folder Name field
   d. Mark Folder Status public.
   e. Enter name of physicians that needs to share folder in Sharing Options and add to Shared User List
   f. Save folder



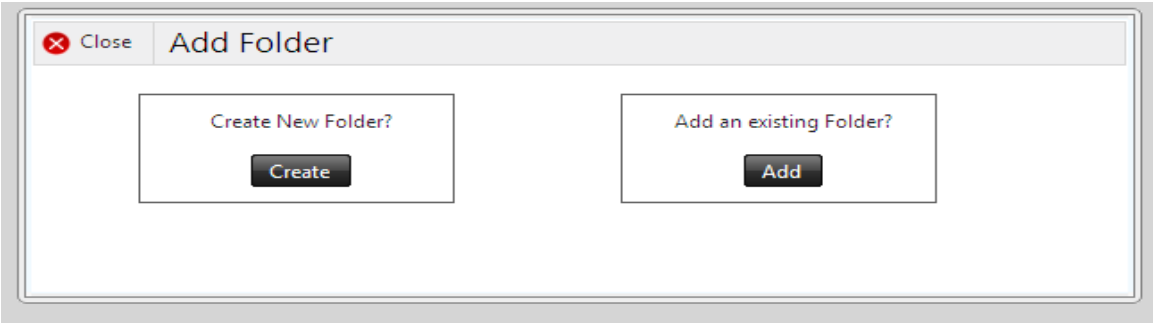
Covering Provider

The Covering Provider Tool in ORB 3 allows all users the ability to easily view the Covering Providers for patients that have not yet been discharged.

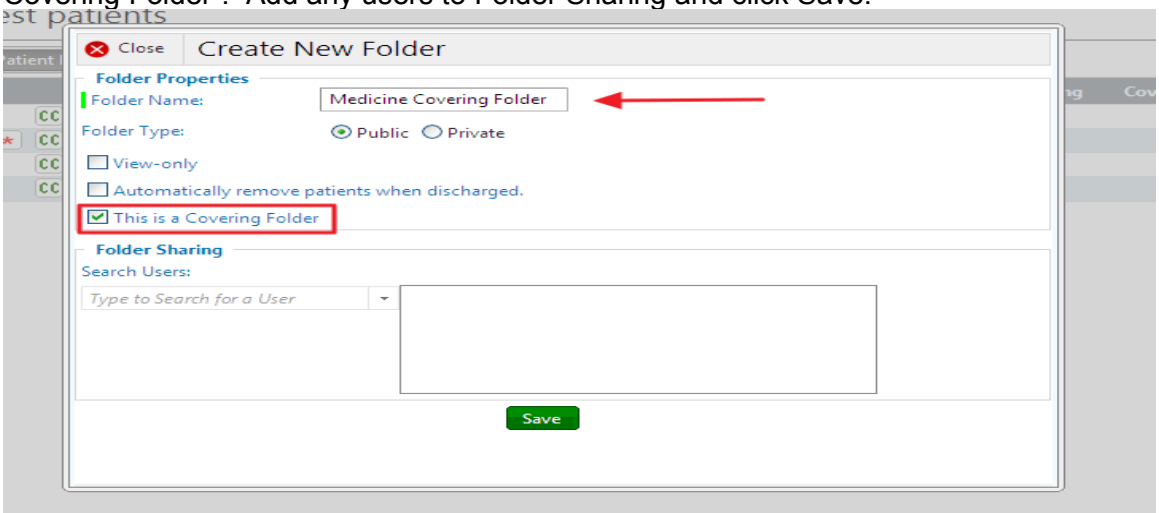
- The covering provider(s) for a patient are shown in the patient list display column called “Covering” and also in the patient header when viewing a single patient.
- When viewing the covering provider, you may click on the name of one of the providers to view the details about all providers currently covering the patient. These details include the provider’s specialty, when they are covering, contact information and any additional information.
- A folder may have several covering providers such as individuals with different specialties and/or different work shifts.

Creating a Covering Folder

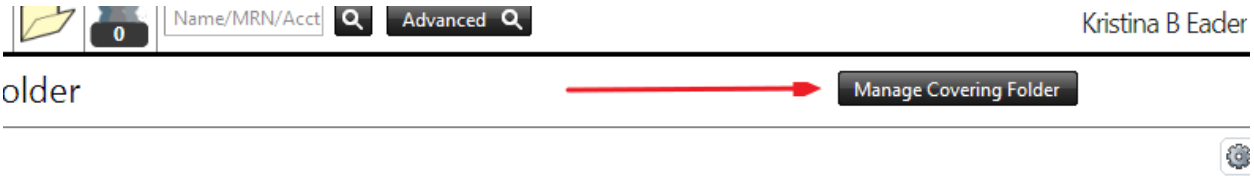
1. From the ORB Home Page, hover on your folders icon .
2. Click on the Add Folders button .
3. Select appropriate option to either create a new folder or edit an existing folder from the list:



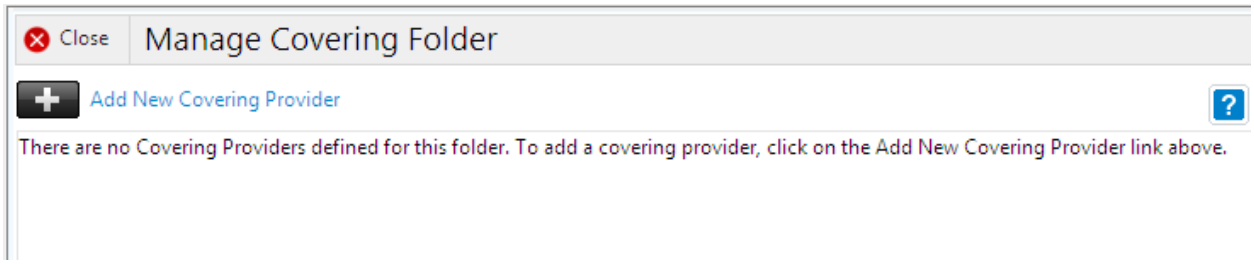
4. Fill in the fields such as Folder Name and Type. Check the box next to “This is a Covering Folder”. Add any users to Folder Sharing and click Save.



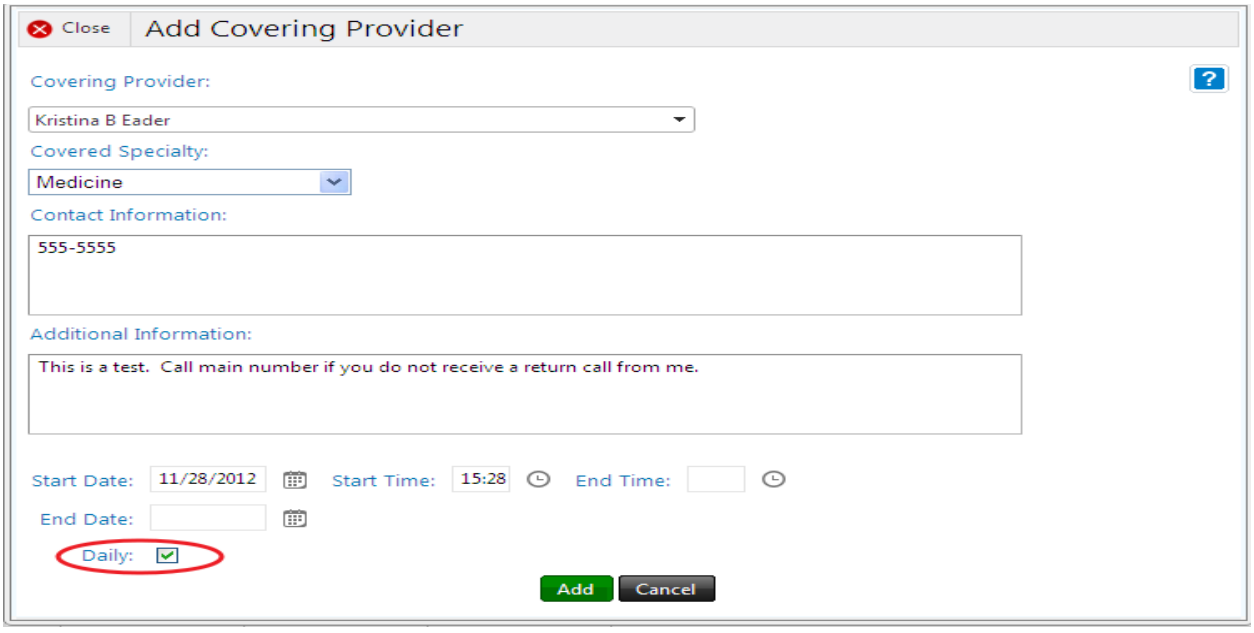
5. Any folder that is checked as a Covering Folder, will have the Manage Covering Folder button when opened. Click on Manage Covering Folder to add a covering provider.



6. Click on "Add New Covering Provider" to add information on each provider.


Close
Manage Covering Folder
Add New Covering Provider
There are no Covering Providers defined for this folder. To add a covering provider, click on the Add New Covering Provider link above.

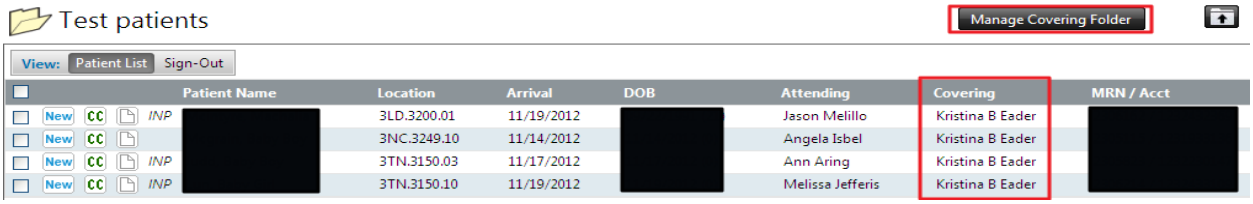
7. Fill in the fields to add a provider's information for the first time or edit what has already been added.
   a. Covering Provider Name and Specialty are defaulted from User Preferences, however they can be changed via the dropdown.
   b. Once the Contact and Additional Information fields are added, they will pre-populate when that provider is selected in subsequent fields
   c. Start date and time default to current



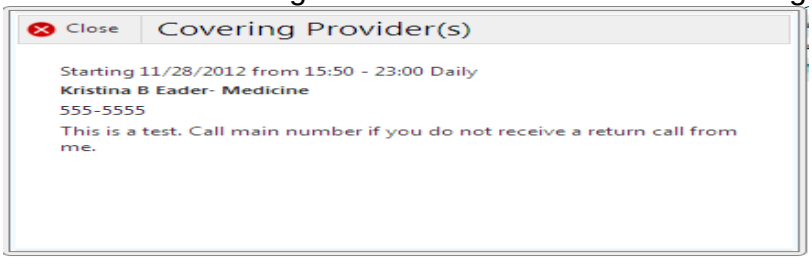
Selecting Daily indicates coverage for each day during the designated Start and End times.

Viewing the Covering Provider Tool

1. Covering Provider is listed in the Patient View if their coverage is active during the time of the Patient View display. The Manage Covering Folder link is also available in the Patient List View.

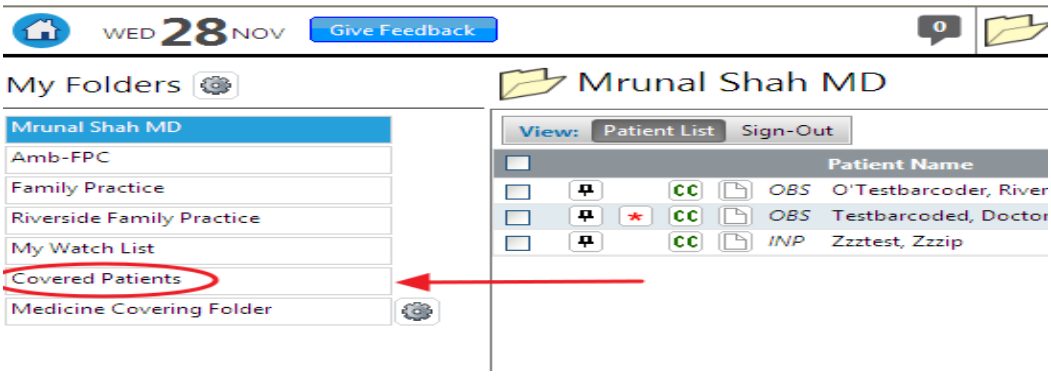


Click on the Covering Providers name on this list to bring up their contact information.


Close
Covering Provider(s)
Starting 11/28/2012 from 15:50 - 23:00 Daily
Kristina B Eader- Medicine
555-5555
This is a test. Call main number if you do not receive a return call from me.

2. The Covering field in the Patient Header will contain Provider entries depending on whether any coverage is present or currently active.

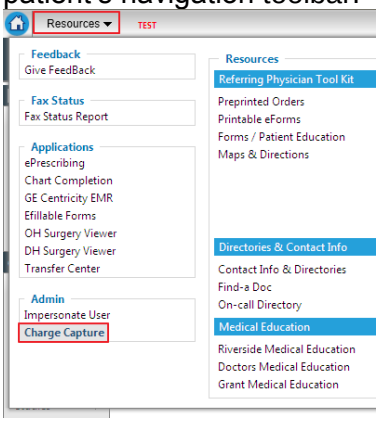
The Covered Patients folder will only show your list of covering patients. This will appear in your folders list:

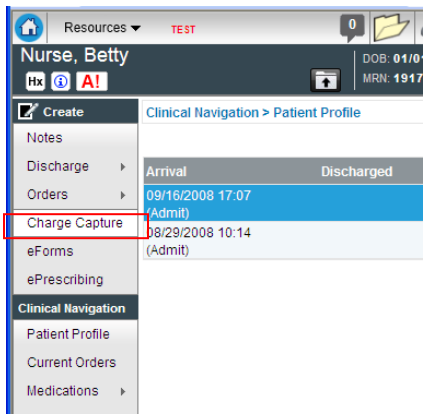


3. If you do not see the Covering column appear on the patient list display, click on the gear icon and add it to the Current Fields list.

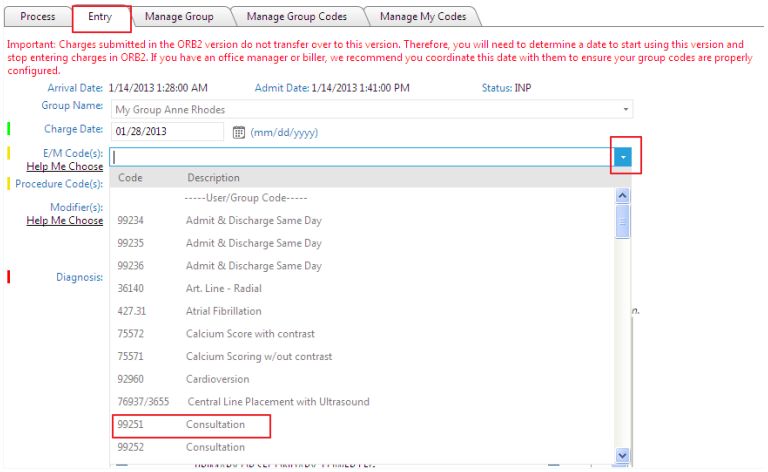
Charge Capture

1. Under **Resources**, select **Charge Capture** or from the Charge Capture link on the patient's navigation toolbar.

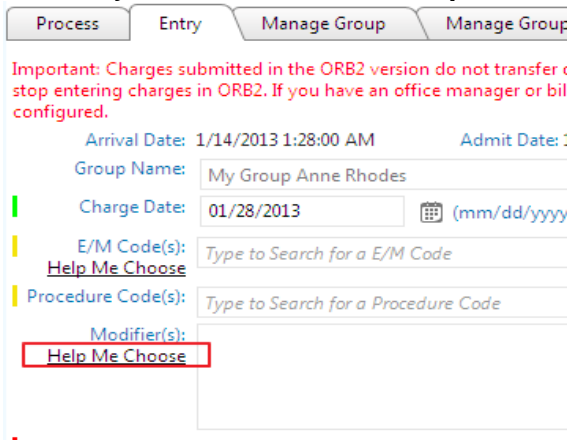




2. Select **group name.**
3. Select **E/M code** by either typing in the number or part of the name, or using the drop down.

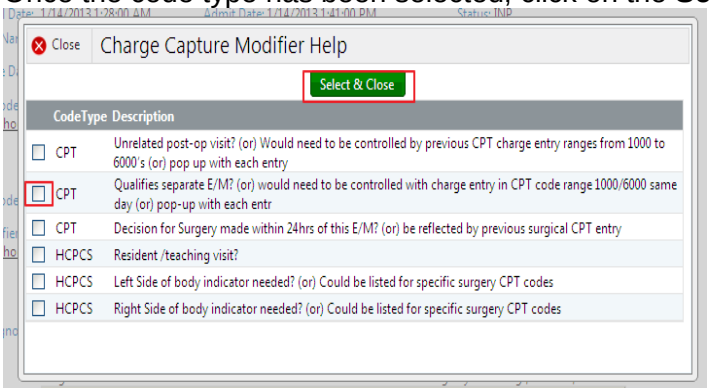

Process
Entry
Manage Group
Manage Group Codes
Manage My Codes
Important: Charges submitted in the ORB2 version do not transfer over to this version. Therefore, you will need to determine a date to start using this version and stop entering charges in ORB2. If you have an office manager or biller, we recommend you coordinate this date with them to ensure your group codes are properly configured.
Arrival Date: 1/14/2013 1:28:00 AM
Admit Date: 1/14/2013 1:41:00 PM
Status: INP
Group Name:
My Group Anne Rhodes
Charge Date:
01/28/2013
(mm/dd/yyyy)
E/M Code(s):
Help Me Choose
Procedure Code(s):
Modifier(s):
Help Me Choose
Diagnosis:
Code
Description
-----User/Group Code-----
99234 Admit & Discharge Same Day
99235 Admit & Discharge Same Day
99236 Admit & Discharge Same Day
36140 Art. Line - Radial
427.31 Atrial Fibrillation
75572 Calcium Score with contrast
75571 Calcium Scoring w/out contrast
92960 Cardioversion
76937/3655 Central Line Placement with Ultrasound
99251 Consultation
99252 Consultation

4. Select the **procedure code** by either typing in the number or part of the name, or using the drop down.
5. Enter any modifiers or use the **Help Me Choose feature**.

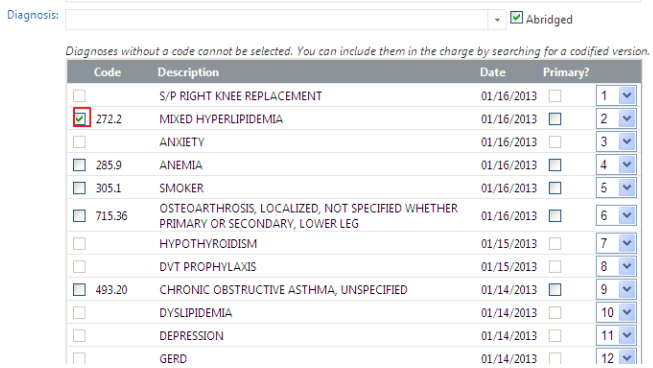


   a. Select the type of modifier by placing a check mark in the box.

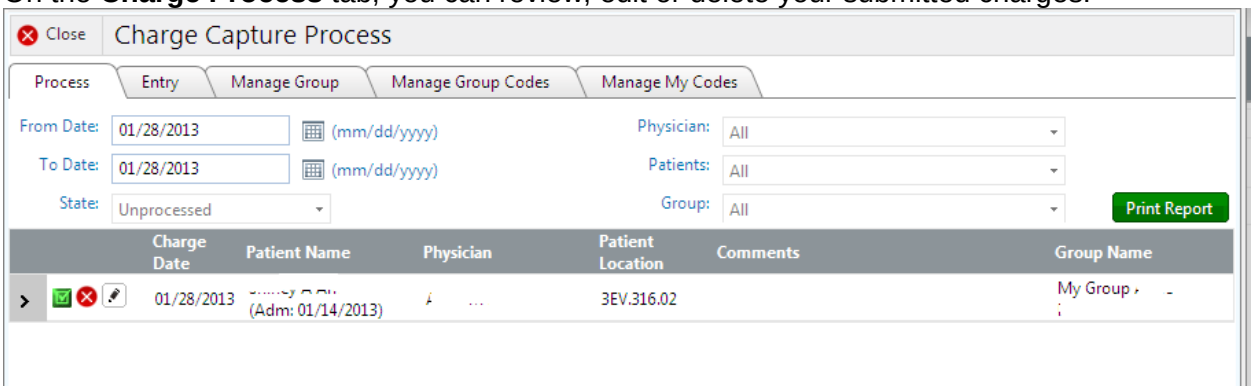
b. Once the code type has been selected, click on the **Select & Close** button.


Close
Charge Capture Modifier Help
Select & Close
CodeType Description
CPT Unrelated post-op visit? (or) Would need to be controlled by previous CPT charge entry ranges from 1000 to 6000's (or) pop up with each entry
CPT Qualifies separate E/M? (or) would need to be controlled with charge entry in CPT code range 1000/6000 same day (or) pop-up with each entr
CPT Decision for Surgery made within 24hrs of this E/M? (or) be reflected by previous surgical CPT entry
HCPCS Resident /teaching visit?
HCPCS Left Side of body indicator needed? (or) Could be listed for specific surgery CPT codes
HCPCS Right Side of body indicator needed? (or) Could be listed for specific surgery CPT codes

6. Enter a diagnosis by placing a check mark in the box next to the diagnosis name. You can also make a diagnosis primary and organize the order from this section.

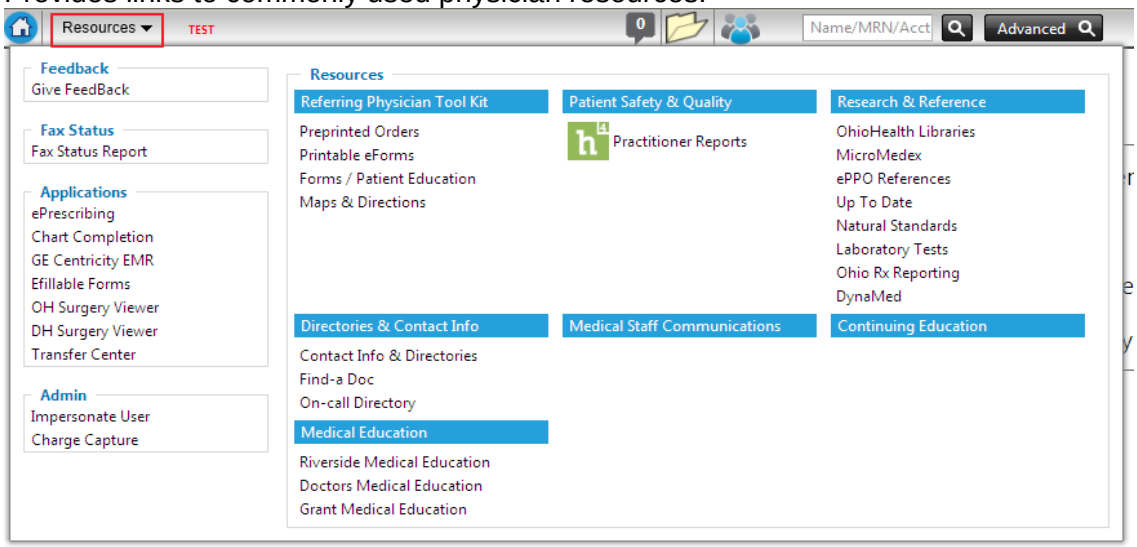

Diagnosis:
Abridged
Diagnoses without a code cannot be selected. You can include them in the charge by searching for a codified version.
Code Description Date Primary?
S/P RIGHT KNEE REPLACEMENT 01/16/2013 1
272.2 MIXED HYPERLIPIDEMIA 01/16/2013 2
ANXIETY 01/16/2013 3
285.9 ANEMIA 01/16/2013 4
305.1 SMOKER 01/16/2013 5
715.36 OSTEOARTHROSIS, LOCALIZED, NOT SPECIFIED WHETHER PRIMARY OR SECONDARY, LOWER LEG 01/16/2013 6
HYPOTHYROIDISM 01/15/2013 7
DVT PROPHYLAXIS 01/15/2013 8
493.20 CHRONIC OBSTRUCTIVE ASTHMA, UNSPECIFIED 01/14/2013 9
DYSLIPIDEMIA 01/14/2013 10
DEPRESSION 01/14/2013 11
GERD 01/14/2013 12

7. Select the **Submit New Charge** button.
8. Charges submitted successfully icon will appear.
9. On the **Charge Process** tab, you can review, edit or delete your submitted charges.

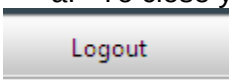


Resources

1. Applications (links) to the following:
    a. Eprescribing
        i. Call Physician IT Services at 614-566-3646 for access and training
    b. Chart Completion
        i. See Medical records
    c. GE Centricity
        i. Link to GE Centricity EMR
    d. eFillable Forms
    e. OH Surgery Viewer
    f. DH surgery Viewer
    g. Transfer Center
2. Resources
    a. Provides links to commonly used physician resources.



3. Admin
    a. Applications (links) to the following:
        i. Charge Capture
        ii. CDI Templates
        iii. Pharmacy Templates
4. Help
5. Log Out
    a. To close your session of ORB click the **Logout** button.



How to Get Help

Physician Education and Technology Services can be reached at 614-566-3646 or physiciantechnology@ohiohealth.com.

Immediate assistance is available by calling 614-566-EDOC.